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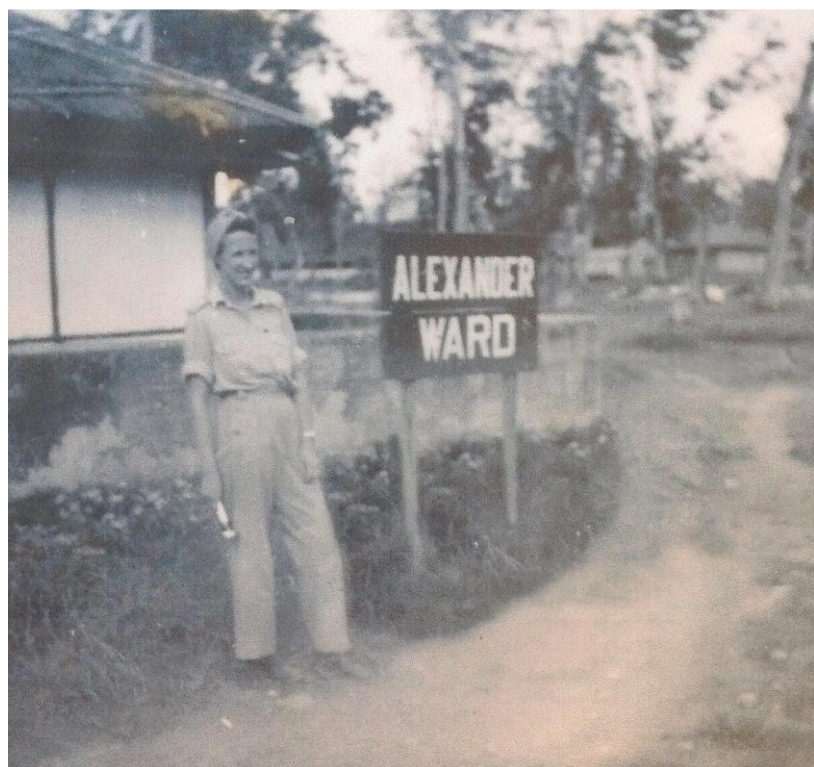
THE BULLETIN

OF THE UK ASSOCIATION FOR THE
HISTORY OF NURSING

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Emily Soper © " going on night duty 66th Indian General Hospital, Manipur Road, North Assam 1945-46"

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Jane Brooks

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Editorial

Jane Brooks, University of Manchester

Welcome to the third Bulletin of the UK Association for the History of Nursing, and my first as editor. I do feel some sense of trepidation following on from John Adams, who is an experienced editor, whereas I am a mere neophyte. I do hope however, that you all find the contents interesting and thought provoking. We have been very lucky receive excellent manuscripts from colleagues all over the globe; it is, I feel a truly international volume.

2013 has been a difficult and sad year for nurses in the UK and for those of us involved in the history of nursing. The death of Lesley Wade, nurse, colleague and historian was one which touched us all. Moreover, her loss is not only to the history of nursing, but also those involved in the care of older people. Lesley's championing of this all too important area of nursing that had suffered poor status and often deplorable staffing levels was influential to many of us who were involved in the care of older people in the 1990s. My own oral history research on the care of older people in the mid-twentieth century, highlighted many of the problems which Lesley endeavoured to fight against - poor status, low staffing levels, a poverty of leadership and inertia from within. The publication of *Sans Everything* in 1967, the Whittingham Hospital Enquiry in 1972, alerted the population at large to the problems faced by not only older adult, but also mental health services. And yet, against all of this Lesley demonstrated to all the vitality of caring for older people.

I turn therefore to the Mid-Staffordshire Hospital Inquiry and reflect at this time on the continuing poor leadership and interest placed on the care of older people. But perhaps the problems have now extended beyond this 'Cinderella service' to hospital and community care for all types of people and patients. As a nurse I am saddened that patients should suffer, as a historian of nursing it is important to acknowledge these problems are not new, its antecedents reach far into the past of our health services. And it is this I think that makes the history of nursing such a vital part of nursing now. It is not enough to blame the current cuts, current nursing education, current hospital structures for problems in the health service, because this is not the first time that our country has faced scandals of poor care in its hospitals. I hope that through studying the history of nursing, scholars can help to offer thoughtful debate on these difficult issues.

May I take this opportunity to thank you all for your support of the UK Association for the History of Nursing over the past three years.

I should also wish to remind readers that postgraduate research studies are offered by all the universities represented by the Association's Committee members. If you are interested in pursuing a postgraduate degree, please do go to the UKAHN Committee page and contact the members for advice.

Recruiting ‘Agents Of Empire’: The Social Backgrounds of the Scottish Women of the Colonial and Overseas Nursing Associations, 1899-1939

Myra L. Valley, independent scholar principally associated with McMaster University in Hamilton, Ontario.

‘Thaim wi a guid Scots tongue in their heid are fit tae gang ower the world’.¹

Miss Agnes Ramsay of Glasgow, aged 34, came to the London headquarters of the Colonial Nursing Association in 1899 to be interviewed for a nursing position within the Empire. Ramsay sailed on December 4, 1899 for Ceylon where she served as Lady Superintendent of the Hatton Nursing Home until she was invalided out in 1902. Miss Ramsay had trained at the Glasgow Western Infirmary for three years. She had worked at the Lanarkshire Isolation Hospital for eight months, served as a district nurse for fifteen months, and had been Superintendent of the Dover Union Infirmary ‘for some months’ prior to applying for a nursing position abroad.² Miss Ramsay was one of the first three Scottish nurses to be recruited for overseas service by the Colonial Nursing Association, established in 1896. In total the Colonial Nursing Association (CNA) recruited 106 Scottish nurses before it became, in 1919, the Overseas Nursing Association (ONA). By December, 1939, this latter body recruited a further 389 Scottish nurses.

This article is part of a wider study which explores the lives, careers, and personal sentiments of these 495 Scottish women who nursed abroad between 1899-1939, under the auspices of the CNA or ONA.³ This study includes an analysis of the lives and work of these nurses up to the termination of their involvement with the CNA/ONA. The variables to be examined include birth place, place of residence at time of application, parental occupation, religion, ages at time of training and application to CNA/ONA, some

consideration of the level of education, and work experience before nurse training, in order to gain an understanding of the Scottish women who joined the CNA/ONA. It is apparent that the CNA/ONA was viewed by many Scottish nurses as a potential career growth opportunity through which they could see the world, and contribute to their profession abroad. The destinations of these nurses were varied, spread throughout the formal British Empire and the zones of economic penetration beyond it. These nurses were necessarily a part of British imperialism. A full comprehension and assessment of these nurses as ‘agents of empire’ – both consciously and as part of the intricate systems of colonization – requires a ‘cradle to termination of overseas contract’ approach.⁴ Who were they? Where were they educated and trained? What prior nursing experience did they possess, abroad, in the British Isles, or at home? The present study establishes the parameters of the investigation as a whole, and examines the geographical and social origins of the Scottish CNA/ONA nurses.

This study demonstrates that there was not a single type of Scottish ‘colonial’ or ‘overseas’ nurse and suggests that ‘simple stereotypes’ of the British-trained nurse abroad are unhelpful.⁵ The nurses were remarkably diverse in their geographic and social origins; they experienced a wide range of pre-training and post-training nursing employments; they utilized the CNA/ONA for exceptionally

brief, or very lengthy, career opportunities, as befit their individual preferences and requirements. The one feature shared by almost all was migration: from birthplace to training centre, to war service, to diverse employments, to the CNA/ONA. A significant proportion had left their native Scotland well before application to nurse overseas. The Secretary of State for the Colonies in 1912 termed them the “ministering angels of Empire”.⁶ In 1900, Mrs. Mary Chamberlain, one of the founding members of the CNA, praised ‘so many highly qualified women’ who were ‘ready and eager’ to serve with ‘unselfish devotion’.⁷ It is arguable however, that these nurses were neither angels nor unrealistically unselfish. They were a highly trained workforce who seized an available opportunity. As skilled workers, they were seeking to maximize opportunities not simply in terms of pay, but in experiences and lifestyle as well. Nurse migration is an important component of historiography, and this present study offers a contribution through systematic investigation of one ethnic group in its antecedents, skill development and pathway.

It is now 25 years since Christopher Maggs wrote about the peculiarities of the late nineteenth century ‘which included economic, political and social expansion by the industrialized nations of Europe and America,’ and gave rise to the specific characteristics of twentieth-century nursing.⁸ As will be demonstrated, the 495 Scottish nurses under study were created within the new British socio-economic system, but Maggs’ statement possesses more relevance than this. As pointed out by Diana Solano and Anne Marie Rafferty, the CNA/ONA nurses benefited from a ‘globalising healthcare market’.⁹ Overseas nurse recruitment and migration reflected ‘the global flow’ of human resources into

the formal and informal British zones of world influence, but also, less directly, the global flow of economic resources into the British Isles.¹⁰ Overall, we may utilize these Scottish nurses to consider another outcome of ‘the drive to professionalize’ within late nineteenth and early twentieth century British nursing.¹¹ Professionalization made these CNA/ONA Scottish nurses marketable throughout the English-speaking world. The ‘British-trained nurse’ was the standard, both for overseas care and for the training of colonized peoples. Without prior U.K. professionalization (and ongoing specialization) the characteristics and cultural meanings of British colonial and overseas nursing would have been very different indeed.

The Context

Scotland, one of the most literate nations in Europe as a result of the eighteenth century Enlightenment, played a significant role through the nineteenth and twentieth centuries in the thorough and systematic colonization of all areas of the British Empire, including commerce, administration, military, colonial education and medicine.¹² As a result, Scots were often positively received when they emigrated to different parts of the world. The exports of the Scottish diaspora involved talent, intellectual capacity, and technology, and its population was well represented within the fields of British and imperial medicine, nursing, and health care. The processes of change, migration and emigration were clearly evident in developments within the field of nursing and, with this, the Scottish nurse.

The image of nursing as a profession in Great Britain underwent dramatic evolution in the second half of the nineteenth century. The Annual Report of the City of Glasgow Fever Hospital for 1865-6 captured the long-standing

negative conception of nursing as ‘... the last resource of female adversity. Slatternly widows, runaway wives, servants out of place, women bankrupt of fame or fortune – fall back on hospital nursing’.¹³ By the close of the nineteenth century, the image, the training and the duties of the British nurse had altered in significant and fundamental ways, influenced in part by the work and prominence of Florence Nightingale. Nursing as an occupation, however, had not yet acquired either a unique body of knowledge or an established skills base.¹⁴ Over this same time frame, nursing was also affected by social change: in particular, the widening of the differential between hospital-trained nurses and servants.¹⁵ Additionally, shifts in public attitudes brought about by the experience of nursing during the first World War and by the higher proportion of women engaged in gainful employment, impacted positively the changing face of nursing.¹⁶ The establishment of the Colonial Nursing Association helped provide an impetus in the development of overseas nursing as a career choice for nurses. Organized in 1896 by a small group of socially prominent British women in London, the CNA was self-funded by voluntary contributions. Its chief concern in the initial stages was the lack of nursing facilities available for British expatriates living overseas. British-trained nurses were to be dispatched to men and women ‘whose duties and avocations lead them year by year to these faraway tropical and often unhealthy climates’.¹⁷ The CNA/ONA worked to recruit qualified nurses both for government service in the Crown colonies and as private nurses to small English communities in foreign territories where British inhabitants had formed local support committees. Between 1896 and the end of 1903, 167 successful British applicants had been interviewed,

appraised, and recommended for specific overseas postings by the CNA; by 1909 the total stood at 467.¹⁸ The CNA/ONA quickly became recognized as the source from which the Colonial Office acquired its principal supply of nurses for government work in the Crown colonies.¹⁹ Prior to World War II, the period under study, the Colonial Office always maintained an arm’s length working relationship with the CNA/ONA.²⁰ In 1940 the Colonial Office formalized its direct involvement in overseas nurse recruitment by establishing the Colonial Nursing Service.²¹ Instead of the colonies running their own individual or regional nursing structures, the result was a unified service. Administrative processes and policies were introduced to promote increased mobility for British nurses to take up, and transfer between, posts across the Empire. However, the Colonial Secretary stated at the time that ‘applications for appointment as Nursing Sisters in the Colonies continue to be dealt with by the Overseas Nursing Association and candidates are recommended by them’.²² From 1896 until the Colonial Nursing Service was disbanded in 1966, the CNA/ONA recruited a total of 8400 British-trained nurses for employment overseas.²³ To date, published studies of CNA/ONA nurses are in their infancy, albeit illuminating and thought-provoking. Overseas nursing was touted in 1936 by Lady Edith Antrobus, Dame of the British Empire and Honorary Secretary of the ONA as ‘the Plum of the Profession’ requiring very special qualifications and a high level of adaptability on the part of the nurse.²⁴ These individuals were the public, and the private, face of the British-trained nurse in the wider world. This evoked both pride, and anxiety. Most CNA/ONA recruits were English, but from the first decade of service there

were also sizable numbers of applicants from Ireland, Wales and Scotland. The first eleven Scottish nurses sent to postings overseas by the CNA in the period from 1899 to 1902 were interviewed and processed at the London headquarters at the Imperial Institute in South Kensington. However, for improved recruitment of future nurses, a Scottish branch of the CNA was envisioned as early as 1900. The minutes of a CNA meeting of April 24, 1900 included an appeal for help in inspiring and recruiting nurses for service abroad, 'especially to Scotsmen, the bond between Scotland and the Colonies being a very close and strong one'.²⁵ The Second Annual Report of the Scottish branch stated that the work of the Association had finally been started throughout Scotland, having been delayed by fund-raising efforts and attention devoted to the war in South Africa.²⁶ While the applications continued to be submitted to the London office, interviews were conducted by the Scottish Committee in Edinburgh. This Committee forwarded its recommendations to headquarters, which in turn arranged the placements with the Colonial Office or with overseas committees. The headquarters' staff also provided mentoring and support for the nurses in the field. The Scottish Committee was unique; all applications from Ireland, Wales, the dominions or elsewhere were administered at the English headquarters. Between 1896 and 1939, the CNA/ONA interviewed approximately 6300 nurses for positions overseas, with Scottish nurses comprising approximately 10% of this total. Over the four decades under review, this percentage varied from a low of 7.4% in the 1900-1909 period, to a high of 15.7% for 1920-29. Approximately 23% of the total number of Scottish candidates interviewed did not proceed to an overseas posting although success rates

for Scottish candidates were significantly higher than for CNA/ONA applicants overall. An internal committee of inquiry of 1910 determined that 'not more than one-third of those interviewed are found, apart from their technical qualifications, to possess the personal attributes which the Committee consider necessary'.²⁷ Overall, the approximately 6300 total interviews by CNA/ONA between 1896 and 1939 led to approximately 3904 nurses serving overseas.²⁸ In round numbers, the success rate for all applicants was 62%; for Scottish applicants it was 77%. The principal reasons cited in CNA/ONA records for failure to obtain an overseas position included lack of candidates' appropriate qualifications, and the applicants' own decisions to withdraw from the process for personal or professional reasons. As well, some applicants were deemed to be 'unsuitable' by the Recruitment Committee, due to factors such as being over the prescribed age limit, failure in the mandatory medical examination, or the perception by the Committee members that the nurse was 'unlady-like'. Such candidates were rejected. In a large number of cases, no comment was entered in the extant records as to why candidates did not proceed to overseas postings.²⁹

The Archival Sources

For purposes of this and subsequent studies, data was gathered from the CNA/ONA Registers of Nurses, and other sources, for all 495 Scottish nurses who were successfully interviewed and subsequently sent abroad, 1899-1939.²⁹ This includes those nurses who interviewed in London, but were designated in the ONA Registers as 'Scottish candidates'. In addition to the information contained in the registers, original completed application forms for 47 of these Scottish nurses are at present

extant in the CNA/ONA archives; these provide more extensive information on this smaller sub-set.³⁰ Only four completed application forms exist for the period up to 1919; the remainder date from the 1920s and 1930s. For this investigation, the total group of 495 nurses will be referred to as the Study Group; the smaller sub-group of 47 will be referred to as the Cohort.

Relevant information was also obtained from the nursing training registers of the Glasgow Royal Infirmary, the Western Infirmary of Glasgow, and the Royal Infirmary of Edinburgh.³¹ The Glasgow Royal Infirmary registers provided, for some trainee nurses, information on dates of training, age at entry, occupation before training, and, for the entries in the 1930s, courses taken and grades obtained. The Western Infirmary of Glasgow training records indicated dates of training, age at admission, religion, courses completed, including number of months spent in each specialty and grades obtained, general performance comments and reasons for leaving. The Royal Infirmary of Edinburgh possesses the most complete records for each trainee. Data included age at application, dates attended, address, marital status, occupation before training, comprehensive comments on performance, certifications, subjects taken, time spent on each specific ward and reasons for leaving. This comprehensive search in the (sometimes incomplete) records at these three training institutions uncovered information on 103 of the 495 future CNA/ONA nurses. Finally, research was undertaken at the National Register House in Edinburgh to secure information on parental occupation at time of birth for 47 CNA/ONA nurses from the Study Group.

Although valuable studies have been made of the history of nursing, the history of some of the more prominent hospitals in both England and Scotland,³² and of various aspects of health care and nursing education in the United Kingdom, the general lack of a detailed examination of Scottish nurses, as a distinct component within the British profession, circa 1899 – 1939, means it is impossible to make, at present, exact comparisons of the socio-professional characteristics of the 495 CNA/ONA nurses to the far larger body of Scottish nurses for this era. Nonetheless, this present study possesses significance in appraising one sub-set of Scottish nurses – the ones who went on to devote at least a portion of their careers to overseas nursing through the CNA/ONA. As there has been limited research on the British CNA/ONA nurses, as a group or cohort, it is not feasible at present to demonstrate how Scottish nurses, in their social backgrounds, education, and experiences, may have been typical, or atypical, of the much larger body of CNA/ONA English nurses, or, indeed, the Welsh or Irish applicants. For these comparative aspects, therefore, this investigation cannot be definitive. However, the 495 Scottish nurses do comprise a clearly defined, active and successful component within British overseas nursing, with a strong presence within the relevant archives.

Place of Residence/Birthplace

Place of birth is known for the 47 members of the Cohort; place of permanent residence at the time of interview by the CNA/ONA is known for all 495 members of the Study Group. Overall, in the Study Group there was a balanced distribution of candidates between rural and urban areas. This aligns closely with the findings in Maria Lorentzon's study of probationer nurses in England in the period from 1903 to 1912.³³ Three-

quarters of all the urban candidates possessed permanent addresses (which in most instances meant permanent family ties) in one of the three major cities of Edinburgh, Glasgow or Aberdeen. This equates to 39.7% of the entire Study Group.

Table 1: Permanent Address for Study Group (495 nurses)³⁴

Urban Scotland	50.9%
Rural Scotland	45.7%
England	3.4%

The percentage of candidates from smaller cities (those with populations from 30,000 to 154,000) increased somewhat over the decades, and constituted overall 13.9% of the Study Group, but never rivalled the dominance of the three urban centres. The remainder of the Study Group possessed permanent addresses spread throughout the small regional centres, towns and villages of Scotland: 16.7% in the 'waist' of Scotland (including the Edinburgh/Glasgow corridor³⁵ plus Perthshire, Stirlingshire, Dumbartonshire, and Kinross-shire); 10.3% in the Highlands (Inverness-shire, Moray, Ross-shire); 9.4%

on the East coast (including Aberdeenshire, Angus, Kincardineshire); 6.9% on the West coast (including Argyll, Bute, Ayrshire and Wigtonshire); 2.3% in the Borders (Dumfries and Galloway, Berwickshire). In at least some instances, the permanent addresses in England were for Scottish parents who had relocated south.

Over time, there clearly existed various patterns of geographic recruitment. For example, the relative decline for the East coast shires was matched by a significant increase from the Highlands. Nonetheless, the overall picture is one of stability: roughly half of the recruitment to the CNA/ONA came from the larger and medium-sized cities, always led by between 33% and 44% from Edinburgh, Glasgow and Aberdeen; the other half arrived at the Association, ready for overseas service and accepted for it, from across the length and breadth of Scotland. To what extent did the geographic diversity of permanent address reflect similar diversities in the places of birth? A study of the 47 nurses of the Cohort suggests a similar overall pattern, albeit with less representation from the three major cities.

Table 2: Geographic Distribution of Scottish Permanent Addresses, by Decade of Entry Into CNA/ONA

Decade	1900-09	1910-19	1920-29	1930-39	1900-39
Edinburgh, Glasgow, Aberdeen	42.0%	39.6%	44.0%	33.1%	39.7%
Smaller Cities	9.3%	11.3%	11.5%	17.2%	13.9%
'Waist' of Scotland	23.3%	16.9%	19.4%	20.9%	19.8%
East Coast	19.0%	16.9%	7.9%	7.4%	9.9%
The Highlands	7.0%	7.5%	10.3%	12.9%	10.8%
The Borders	0%	3.8%	2.4%	6.1%	2.4%
West Coast	0%	3.8%	4.8%	2.5%	3.4%

Table 3: Birthplaces for the Cohort (47 nurses)

Edinburgh, Glasgow, Aberdeen	21.3%
Smaller Cities	25.5%
'Waist' of Scotland	14.9%
East Coast	7.0%
The Highlands	12.7%
The Borders	8.5%
West Coast	0.0%

A comparison for the Cohort of their places of birth with their stated place of permanent address at time of application reveals that just over one half (52.3%) specified identical places (with three not indicating permanent addresses on the application form). For another 34%, although family had relocated within Scotland, the only emerging pattern indicated that no major shift to larger urban centres had occurred. One significant development is that several of the Cohort nurses (11.4%) had transferred their permanent addresses to England, and one had moved to Australia. Of these, none indicated a major city as their new address.

The completed application forms also specify the current postal address for the Cohort nurses. This was significantly different from their places of birth. A total of 43.5% applied to the CNA/ONA from outside of Scotland, with the largest number of them, 39%, living and working in England. The remainder applied from Australia and India. Approximately 29% were living in Edinburgh, Glasgow or Aberdeen at time of application, the majority of these having been born in smaller centres. Another 8.7% were residing in the smaller urban areas of Scotland. Only 19.6% of these nurses applied to the CNA/ONA from smaller communities, notably from Ayrshire and

Nairnshire. This major shift from rural to urban locations indicates that migration of nurses to larger Scottish cities, and (for 43.5%) further afield, had already occurred by time of application to the CNA/ONA. Geographic mobility beyond Scotland was already a fact of life for these nurses. This reinforces Maggs' demonstration that female migration showed a 'constant movement' from rural to urban areas during this period of time, with long-distance migration being preferentially towards 'one of the great centres of commerce and industry'.³⁶ What is perhaps unique for the CNA/ONA nurses is that their successful applications transported these 'urbanized' Scottish nurses to many various locations within the Empire and the wider world.

Parental Occupation

The occupations of fathers, used as an indicator of socio-economic background in the absence of other methods of determining social class of entrants³⁷ are, for the purposes of this investigation, grouped into five categories: agriculture and fishing; trades and industry; retail and service; professional; other (See Appendix A for details). A sampling of original birth records in the National Register Office for 47 nurses from the Study Group, spread over the decades of study, reveals the following: approximately 55.3% of fathers of these future nurses were employed in the trades and industry category, with occupations such as coalminer, pipe maker, tailor, and cooper. This category predominated for nurses who entered the CNA/ONA during each of the four decades of the study. Another 17% were employed in the agricultural and fishing category (e.g. farmer, crofter, fisherman); 12.7% were in the retail and service category (e.g. wine merchant, hotel waiter, commercial traveller); and 15.0% can be placed in a professional category (e.g.

medical practitioner, electrical engineer, teacher).³⁸ With reference to the Cohort, of the fathers' occupations listed on the 47 extant application forms at the time of the nurse's approach to the CNA/ONA, only 10.6% were in the trades and industry category; 31.9% were in agricultural and fishing (e.g. farmer, trawl owner, skipper and part owner of a fishing vessel, dairy owner); 17% in the retail and service category (e.g. innkeeper, billiard room owner, garage owner); and 36.2% in the professional category (e.g. naval officer, police inspector, chemist).³⁹

The desired social status of early twentieth-century British nurses was that of an 'educated lady', a concept of which applicants would be aware.⁴⁰ Striking differences exist between the social backgrounds of the CNA/ONA Scottish nurses for the sample drawn from birth certificates and the self-declarations on the application forms submitted by the Cohort. What may be categorized as 'professional' stands at 15.0% for the former, and 36.2% for the latter. Agriculture and fishing is 17%, and 31.9%, respectively, but the key difference is the number of daughters of 'farmers' in the Cohort. There were three farmers listed on the 47 birth certificates, and ten farmers on the applications. Others in the Cohort had fathers who owned dairies and fishing boats; owners, overall, were sparse amongst the birth registrations. Upward social mobility over time could account for some of the discrepancy. Certainly, a nurse at an average age of 31 at the time of her approach to the CNA/ONA could have parents who had prospered since her birth. Nonetheless, the overall pattern of self-reporting at time of application is striking. Although for some of the Cohort, their father's occupation was stated in a straightforward manner (e.g. 'police

inspector,'), others were more ambiguous ('engineer', 'civil servant'). Given the mix of backgrounds from which nurses generally came, the candidates must at least 'present' as lady-like, as judged by the CNA/ONA recruitment committee, in order to be accepted for overseas duty. There was no reference to clergymen, gentlemen or lawyers as a parental occupation for any of the 47 nurses in the Cohort, or the 47 sampled from the original birth certificates. There were only two medical doctors (one in each category), only two officers in the British Navy (Cohort) and none for the British Army or Indian Army, and only one teacher (Study Group). Were it not for the ten farmers for the nurses of the Cohort, it would be difficult to characterize any significant proportion of these 94 successful applicants as the product of more than the 'middling' middle class, or lower – sometimes substantially lower.

Religion

Miss Mary Lamb, aged 31, daughter of a farmer in the Braes of Glenlivet, Banffshire, applied in September 1931 to the ONA and was sent in 1932 to St. Ann's Mental Asylum in Port of Spain, Trinidad, as Head Female Attendant. She had trained at the Craighouse Mental Hospital in Edinburgh from 1919 to 1923 and held a mental care certificate, the Central Midwife Board certificate (CMB), and was a state registered nurse (SRN). On completion of her contract in 1935, Lamb opted not to renew it, but requested instead a posting in the Federated Malay States. Unfortunately, the Committee of the ONA saw 'no prospect of further appointment' through the Association as Miss Lamb did not possess a general training certificate (GNC).⁴¹ Miss Lamb was unusual, not only in this regard of being deemed unsuitable

Table 4: Occupations of Fathers: A Sample of 47 Birth Certificates for the Study Group (SG) and all 47 Applications for the Cohort

	1900-1909		1910-1919		1920-1929		1930-1939		Overall %	
	SG	Cohort	SG	Cohort	SG	Cohort	SG	Cohort	SG	Cohort
Trades/ Industry	5	0	3	0	12	2	6	3	55.3%	10.6%
Agriculture/ Fishing	1	1	0	1	3	3	4	10	17.0%	31.9%
Professional	0	1	1	1	3	2	3	13	15.0%	36.2%
Retail/ Service	1	0	0	0	3	0	2	8	12.7%	17.0%
Other	0	1	0	0	0	1	0	0	0	4.3%
Total	7	3	4	2	21	8	15	34	100%	100%

following a completed tour of duty because she did not hold the GNC, but also for the fact that she was one of only two Scottish applicants known to have been of the Roman Catholic religion. The applicants' religion for both the Cohort and the 29 future CNA/ONA nurses who trained at the Glasgow Royal Infirmary and the Western Infirmary of Glasgow was predominantly Protestant. All 29 from the training registers were members of Presbyterian churches (Church of Scotland, United Free Church, and Congregational Church). In the Cohort, 52% of applicants were Presbyterian,⁴² and another 28% declared their religion as protestant with no specific denomination noted. Of the remainder, 15% identified as Anglican, of either the Scottish Episcopal Church or Church of England, and only 4.3% (the afore-mentioned two nurses) as Roman Catholic.

In many instances, the CNA/ONA was reluctant to recommend Roman Catholic applicants for overseas postings.⁴³ The question on the application form relating to religion inquired simply 'of what religious denomination' a candidate was. However, the candidate's references were required to exhibit that she 'should show

a good past behaviour and reputation and she should have had a religious upbringing, with a responsible attitude to life and with 'distinct standards of right and wrong'.⁴⁴ There was no requirement that any referee or guarantor should be a cleric and only four out of the 47 members of the Cohort named members of the clergy as a reference. The majority used their supervisors from previous nursing employments as personal references. Very little direct evidence exists in the records of nurses' religiosity or spirituality. As this documentation is administrative and bureaucratic in nature, it would therefore not be the ideal location to look for, or assess, spirituality. Separate British organizations existed to encourage, train, and mentor women who desired to nurse within Christian institutions overseas.⁴⁵ It is instructive that the CNA/ONA Registers of Nurses did not routinely note the nurse's religion. In these registers, religion arose in the section on comments when the religion (principally Roman Catholic) made an otherwise suitable applicant difficult to place.

Conclusion

This article has explored the backgrounds of Scottish recruits to the CNA/ONA prior to their entering the nursing profession and suggests significant diversity of early life experiences. While the nurses were raised in virtually every shire of Scotland, there was a balanced distribution between rural and urban areas. Some came from relatively affluent families, but most – particularly at the time of birth of the future nurse – were considerably less well off. Many were the products of households participating in the new industrial and commercial Scotland; others came of age within the more traditional pursuits of fishing, farming, and coalmining. Religious affiliation was perhaps the most consistent variable with the great majority identifying as protestant.

The limited research available on British nursing recruits of this generation precludes direct comparison with the larger Scottish and British cohorts. However, Rafferty's study does show that English recruits to the CNA/ONA came from a similar range of social backgrounds as this Scottish sub-set, and that recruitment from the middling levels of society, the newly skilled working class, and small landowners was standard.⁴⁶ This current study confirms the inconsistency or lack of stereotypical profile relative to the 'colonial' or 'overseas' Scottish nurse and suggests that further investigation into the education and experience of the nurses would be informative. Given the above, the next questions are: by what routes, and how fast, did these potential 'agents of empire' arrive at the CNA/ONA?

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APPENDIX A

Occupations of Fathers for 47 Nurses from Study Group (at birth) and 47 Nurses of the Cohort

47. (At application)

	1900-1909		1910-1919		1920-1929		1930-1939		
	At birth	Cohort	At birth	Cohort	At birth	Cohort	At birth	Cohort	Totals
TRADES/ INDUSTRY									
Building trades	2		1			1	2	1	7
Carter					2				2
Clocksmith					1				1
Coalmining	1				1				2
Cooper					1				1
Gilder master					1				1
Ironmonger					1				1
Ironworker	1				1				2
Joiner/ Sawmiller			1				3	1	5
Printer			1			1		1	3
Railway worker					3				3
Shoemaker	1								1
Tailor					1		1		2
AGRICULTURE/FISHING									
Cattle dealer								1	1
Dairy owner		1							1
Estate Factor				1					1
Farmer						3	1	7	11
Fishing industry					3			2	5
Gameskeeper	1						1		2
Harbour pilot							1		1
Ploughman							1		1
PROFESSIONAL									
Chemist								1	1
Civil Service						1		2	3
Engineer		1		1	2		3	8	15
Medical doctor					1			1	2
Naval officer						1			1
Police inspector								1	1
Teacher			1						1
RETAIL/SERVICE									
Travelling sales							1	4	5
Retail	1				1		1	4	7
Food Service					2				2
OTHER		1						1	2

Public health nursing in Italy, a postcolonial perspective

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Public health nursing emerged in Italy at the end of World War I at the intersection between local aspirations to the optimization of the national 'biological resources' and the tension toward an international standardization of public health methods interpreted by new or renewed transnational institutions and agencies. Public health nursing emerged, in the same period, in many different countries in east and west Europe and Asia under the auspices of USA-based transnational agencies such as the Rockefeller Foundation or the American Red Cross.¹ It was the latter that patronized public health nursing in Italy, an issue which will be returned at the end of this paper.

Public health nurses were trained nurses who were intended to teach working class people, at home (as well as in schools and factories), hygienic norms, healthy conducts, 'proper' bodily practices and aptitudes, modern ways of managing one's own body and 'biological resources' in order to gain an 'happy, vigorous and productive life'². This paper does not take into account the history of nursing or public health nursing in Italian colonies, even though it would be worth tracing the history of Italian voluntary nurses during the conquests of Libya in 1911³ and Ethiopia in 1935⁴, or that of the Italian Red Cross school for voluntary nurses in Tripoli, or, again, the history of Italian nurses working in Tripoli and Bengasi or in 'Africa Orientale Italiana'. We will briefly come back later on the School *Principessa Maria Pia* for 'Arab nurses' set up in Tripoli in 1935, few years after the end of a bloody so-called 'pacification campaign' in Libya⁵.

It is the intention in this paper, instead, to

try to take very seriously the idea that colonialism has affected and affects metropole⁶. colonies and former colonies at the same time though, clearly, in radically different ways⁷. The 'colonial discourse' haunted – and continues to haunt – the metropole in different and pervasive ways. Colonial repertoires, especially those flourishing around the idea of 'civilizing mission', offered a powerful source of meanings, symbols and imagery that could be used in different contexts, such as public health and nursing. I would like to work with the idea that metaphors, meaning, concepts, but also practices shifted back and forth between metropole and colonies, producing a sort of 'mirror effect'. Anyway in doing so I am taking very seriously Warwick Anderson's admonition:

It is important to consider the 'colonial' as a process and category in the history of medicine and public health more generally. By this I mean more than mere accumulation of homologies or family resemblances, the notion that if it looks like something else it must somehow be related – that all medicine, for example, is somehow colonial in its relation to the body of the patient. Rather, I am suggesting that one can put together a specific genealogy of metaphors, practices, and careers that links the colony with the metropole and with other colonies, that one might follow people, technologies, and ideas as they move from one site to another⁸.

Through the analysis of different texts produced by and on public health nurses in Italy I intend to trace back a genealogy of some of these metaphors, meaning and practices that moved between different colonies and colonial contexts and different metropolises.

Back and forth

The starting point in this inquiry is the issue of *Infermiera Italiana*, the official journal of the Fascist Nurses Union (Sindacato nazionale fascista infermiere diplomate), published after the proclamation of the empire by Mussolini at the official end of the military conquest of Ethiopia. The opening article asserts that as soon as there will be enough trained nurses to fulfil the needs of the metropole, many voluntary nurses will surely be ready to leave for Ethiopia where:

we have to take care of 7 million poor, childish, lazy, cruel, superstitious, diffident, ungrateful, greed, indolent, dirty creatures who can become victims of epidemics and leave entire regions empty. [In Ethiopia] we have to protect the children who are our hope. We'll be able to create a new population out of those children, the seed of our teachings won't be planted in vain. In her generosity, Italy does not want colonies in order to exploit them: Italy doesn't want to rule on deserts, but on hard working, healthy, happy, reproductive populations: that is why we have to create a perfect sanitary system in Abyssinia⁹ [Ethiopia].

What is particularly significant for the purposes of this article, is the fact that the order to give their contribution to the colonial enterprise is not assisting and work nurses are invited to perform in hygienically defending Italian soldiers or

settlers, but making the colonized people 'laborious, healthy and happy' and 'civilizing' them. What I will attempt to do is to delineate the background of these assumptions. It is arguable that the public health nurses found the words of the author of this article –Rosanna Fambri, chief of the Fascist Nurses Union, director of the journal and– rather familiar.

Public health nurses' work with Italian working class people was always described in a similar way. What public health nurses were supposed to do was disciplining through example - in the most plain, persuasive way - the hygienic conducts and body practices of simple, 'childish' 'ignorant', 'superstitious', 'irrational', sometimes 'apathetic' people. They had to bring into their 'poor', 'dark', 'stinky', 'crowded' houses the 'rational and modern' teaching of social hygiene, they had to make diffident people trust medicine and physicians, convince them not to follow the 'irrational' and 'superstitious' advices offered by the women of the neighbourhood, 'le comari', or traditional healing practices.¹⁰ They had to teach them how to manage themselves in order to be healthy, happy, productive and reproductive, how to become good mothers and hard workers.

It is not a surprise, then, that the repertoires of the 'civilizing mission' emerged here and there in the discourses about public health nursing. 'Missionaries of hygiene', 'soldiers of peace', are the titles often used to describe this kind of nurses. A pamphlet by the Croce Rossa Italiana also recommended that public health nurses add a 'work of civilization' to hygienic assistance.¹¹ This was particularly evident in the description of the work of public health nurses in places afflicted by malaria, often in the south of Italy.

What has been named a process of 'internal colonization' and a rich history of

institutional and popular anti-south racism - that has profoundly shaped the process of nation-building in Italy - sustained a vision of southern people as less 'civilized' and less 'white' than Italians from the north¹². Public health nurses were described as having to deal with the 'apathy', the 'prejudices', and the 'superstitions' of the local peasants, often refusing quinine, distrusting physicians and medicine and tending to have 'irrational behaviours' such as hiding their disease. The words of Irene di Targiani Giunti, who was the chief of the Italian Red Cross nurses and secretary of the Italian Association of Trained Nurses (Aniti), about public health nurses in rural districts are particularly explicit: 'the secret of the public health nurse in rural districts is knowing their soul. From seven years ago on - when we began this work of penetration in rural districts - real miracles happened, especially in the most abandoned, most primitive places of southern Italy [...] Together with the vocation that moves these missionaries, without which they could not survive this life of deprivation, we came to be persuaded that science and experience are not less necessary'¹³.

Public health nurses were also described as 'explorers'¹⁴, looking for sick people and exploring poor houses and neighbourhoods in order to bring back to physicians (and institutions) useful information. They were intended to 'penetrate'¹⁵ working class families. Ettore Levi, founder of the Istituto di Previdenza e Assistenza Sociale, one of the strongest advocates of the importance of public health nurses, called them 'personnel of social penetration', 'missionaries of this essential work of civilization'¹⁶.

The next pages will focus on a particular and recognizable 'trajectory' along which the 'colonial discourse' has come to be a source of meaning, metaphors and

imagery in the construction of public health nursing. The analysis of one of the few books published in the 1920's on the topic of public health nursing and especially addressed to nurses or future nurses will highlight this 'trajectory'. The 1926 book, *Quasi un romanzo, linee di studio e di pratica per le infermiere del Littorio*¹⁷ was a sort of mix between a public health nursing textbook and an educational novel that described what a nurse had to be like and what was her mission. Its role as a public health textbook, despite its fictional content, cannot be downplayed during this inter-war period, as there were very few manuals available for public health nursing. It was published in a series called 'Biblioteca per le giovani italiane (library for Italian girls)'. Elisa Majer Rizzioli, author of the novel/manual, was among the founders of the female fascist organization 'Fasci Femminili' - an organization strongly committed to the education of nurses - and one of the most important exponents of the female fascism in the 1920s¹⁸. She took part to the 'Marcia su Roma' as a nurse. Rizzioli was also one of the 66 voluntary Red Cross nurses who took part, on a hospital-ship and under the guide of the Duchess Elena D'Aosta, to the military expedition that brought to the conquest of Libya at the end of 1911¹⁹. She later published a memoir on this experience in which she expressed all her patriotic support for Italian will to bring 'civilization' to the 'black, turbid and barbaric' Africa, and a rampant racism against 'Arabs', described as 'cruel', 'non-human', 'animal-like', 'disloyal' and, most of all, 'dirty'. This memoir's first pages can be read as an interesting 'hymn' to whiteness. At the beginning of the book Rizzioli evokes the ship

[...] which brings the white women, along with white beds, white cotton

and bandages, and goes in the pure morning. Who waits for the white women with the red cross? Who waits for the pure and white hands of the sisters and for the healings, the bandages, the sweetness? Go ahead my white ship, Italian soldiers wait for you and for the white sisters²⁰.

This brief piece could offer us and interesting insight into the troublesome self-construction of Italian whiteness and its fundamental links to colonialism, women's bodies, hygiene and sanitation and perhaps even to the history of the 'white sisters' of the Red Cross. For the moment I will simply add that this memoir was published in 1915, when Italy entered World War I, in order to offer an example to all the women – especially middle and upper class women – willing to become nurses in order to do something for their homeland in wartime. The importance of Elisa Rizzioli's experience with the conquest of Libya, is important for this narrative, not only in order to provide a genealogy of her own 'civilizing and colonial fantasies', which this article will explore, but also because this campaign witnessed the first appearance of voluntary female 'modern nurses' trained by the Croce Rossa Italiana (CRI) in a war context²¹. The work of CRI voluntary nurses during the conquest of Libya has been later perceived as a sort of 'test bench' for the involvement of female middle-class nurses in World War I. This war is a fundamental turning point in the history of nursing in Italy and a catalyst for the rise of the figure of the female 'modern nurse'²². It could also be argued that the colonial war in Libya, represented a step in the emergence of this figure: another example of the pervasive influence of colonialism in Italian nation-building.

The main character in *Quasi un romanzo* is

an upper class girl called Lorenza, who comes from a 'frivolous and wealthy' family. Due to an unlucky love affair she wants to 'forget herself' and her problems by giving all her energies 'to the poor populations that have remained backward in the scale of civilization'²³. She wants to become a 'pioneer of civilization', both a missionary nun and an explorer. For this reason she goes to her aunt, an older philanthropist and nurse, in order to get some advices. The latter convinces her that, in order to realize her purposes, she has to be trained as a nurse. In a central dialogue between the two characters, the aunt literally re-orientates the girl's aspirations, taking the chance to explain to her what a nurse is basically supposed to do:

Shall I be doctor? – Not at all. You'll be a propagandist of hygiene and ethics: these are the bases of society. - I'll look for the most inhospitable area of Africa. – wouldn't it be better if you went to Somalia, where the Dutch of Abruzzi [...] has changed the course of the river Uebi Scebeli and has created plenty of cotton fields? [...] –Yes, my aunt, I'll create schools, getoghetters, everything for the children. They'll learn Italian, our religion, our songs..- First of all you'll teach them how to stay healthy? – Teach children how to stay healthy? – Sure. If they'll learn that they have to wash their teeths every morning, they'll keep them healthy, if you'll teach them to wash themselves they'll keep their skin healthy, if they'll be controlled so that they'll seat at the table in the proper way, we won't have myopic or hunchbacked [...] I'll have so much to do down there. – And what about here, in Italy: who will stay here to work? Only women already tired for

the work they've done during the war, like me and my sisters of the Red Cross? - I'll work here with you till I'm trained, ok?

In this dialogue the aunt guides the girl's aspirations from a vague and 'childish' desire to 'civilize uncivilized populations' to a more concrete and realistic involvement in Italian colonialism and finally she re-orientes her toward the desire to 'regenerate' Italians themselves. In Rizzioli's text 'the civilizing mission' offers a powerful source of meaning that supports the poetic and technical construction of what is represented as the 'ideal nurse'. On the other end, if the 'colonial discourse' could represent a source of meaning in the construction of public health nursing, the latter could offer inspiration in the construction of colonial practices as well. Italy, as a colonial power, has been – beside the rhetoric on the 'civilizing mission' – 'particularly reluctant to create institutions and infrastructure dedicated to the desired "civilization of natives"'²⁴. Italy has been a bloody, brutal and not particularly 'sophisticated' colonial power. It is worth noting, though, that some discourses about the 'penetrating potential' of hygiene circulated in Italy as well as in other empires²⁵. Pasquale Petiti, general director of health bureau in Somalia and then director of the military hospital in Tripoli, stated in his 1936 treatise *Consigli pratici di igiene e malattie tropicali* that health assistance 'offers a tool of penetration that has a positive influence on the spirit of these primitive populations'²⁶. In a short article on the training of Maori public health nurses and on their use in the regulation of Maori communities' health, Ettore Levi remarked: 'Colonial experience taught us what a powerful tool of penetration health assistance can be, if we intend it

not only as a greed way of defending Europeans from epidemics, but especially as an effective way to teach natives hygiene and to upgrade them materially and morally. We call colonial authorities' attention on the social value of this experiment and we invite them to adopt similar practices that can bring good results even at a political level'²⁷.

There is no evidence as to whether this advice was actually read by Italian 'colonial authorities', but what is known is that in 1935 the governor of Libya Italo Balbo opened a school for 'Arab nurses' with the aim of teaching them 'first aid and infant hygiene'²⁸. The creation of this school was followed a year later by the opening of another school of the same kind in Benghazi. As Balbo explained in 1938, the spreading of hygienic notions among Libyan women was 'fundamental for the civilization of the Arab family'²⁹.

Travelling concepts

The idea of a link between hygiene, good health and civilization, between good standards of hygiene and health and the development of 'good citizenship'³⁰, was what had led American Red Cross' work in Europe toward the end of World War I, as Julia Irwin³¹ has demonstrated. This link between fitness, health and "good citizenship" was profoundly rooted in the Progressive era's way of thinking³².

If this was the rationale at the base of American Red Cross' intervention in Europe, developing 'good citizenship' through hygiene was particularly important in a country like Italy that was the origin of a massive flow of immigrants to the US: a flow that the US government was just about to limit with new laws. 'No one who has watched the embarkation of Italians from their own country or their arrival at the ports of immigration in America can be insensitive to the desirability of common standards of public welfare work in the two countries'³³

stated the final report on the work performed in Italy by a Commission for Tuberculosis set up by the American Red Cross in 1918³⁴. The inception of “modern methods” of public health management and, most of all, hygienic education in Italy would have been useful for US in order to help the construction of “valuable citizens” out of not-completely-civilized immigrants prior to their arrival in North America:

assistance to Italy in this field of public education [hygienic education in schools] – stated American Red Cross representatives in the Report – [...] in the light of the enormous annual tide of immigration, would bring a large return [to Us] in the elevation of valuable citizens.³⁵

As has been discussed at the beginning of this paper, the American Red Cross profoundly influenced the inception of public health nursing in Italy since “the most important implement of an active campaign in public health was recognized by the commission to be the public health nurse or visitor, who would carry the instruction given by the physicians on the dispensaries directly into the homes of the applicants for relief. This agent was practically unknown in Italy”³⁶.

Public health nursing in the US, in the previous years, had already proved to be a useful ‘tool’ for the management of lower classes’ health and bodies and especially for those of immigrants³⁷ (and among them Italian immigrants) and for their ‘civilization’, literally the process of making them into ‘good American citizens’. At the of World War I American Red Cross, under the guide of Mary Gardner, who was to be the chief of the US National Association for Public Health Nursing, patronized the inception of

public health nursing in a country that was the origin of a huge immigration flow. American Red Cross helped the opening of the first public health nursing schools, provided teachers, programs and materials for their start up and trained the Italian nurses that were going to open new schools for ‘assistenti sanitarie visitatrici’. In this process it had the opportunity to transmit its own ideas about public health nursing and hygiene, and their ‘civilizing potential’ to Italian institutions and nurses.

Conclusions

This article discussed some of the multiple ‘trajectories’ along which the repertoires of the ‘civilizing mission’ have travelled back and forth between Italy and its colonies haunting the development of public health nursing. In the last paragraph we explored a further trajectory of the concept of ‘civilizing potential of hygiene’, a trajectory that originated in a country hosting completely different ‘Italian colonies’ – interesting enough, this was the name given to Italian immigrants communities in the Us at the time³⁸ – where other forms of ‘racialization’³⁹ as well as different methods of ‘civilization’, were put in place.

As asserted by recent scholarship, ‘postcoloniality’ in the Italian context has a ‘transhistorical and geographically expansive nature’⁴⁰ that can be better understood intertwining colonization, emigration and the marginalization of the South. That is why, in appraising the emergence of public health nursing in Italy in a postcolonial perspective, it is worth adopting a wider concept of ‘colonial’.

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Labour support and high-touch care: A lost art in perinatal nursing?

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Background

This paper provides a historical perspective on registered nurses' labour support provision within the North-American hospital context. In North America, registered nurses provide in-hospital care for labouring mothers and labour support is considered an important nursing role as distinct from that of midwives¹ or, within the North-American context, nurse-midwives who have obtained specialized training in midwifery.² Internationally, there is overlap in the roles of midwives and nurses during labour and birth;³ in some countries, such

as Norway,⁴ midwives delivering low risk infants in-hospital provide all in-hospital care; whereas in others, such as Canada and the United States, nurses provide care during labour and birth at all levels of risk, while the physician, midwife, or obstetrician manages complications and/or seeks referral for complications, and delivers the infant.⁵ Additionally, in the United States, there also exists nurse-midwives, who are nurses that continue education to become midwives; they provide prenatal, labour and birth, and postpartum care.⁶

In this paper we focus on the role of registered nurses providing labour support to women in labour, sometimes also referred to as obstetrical nurses. Labour support by these nurses is generally defined as advocating for mother's choices and providing emotional, physical, and informational support during labour and birth.⁷ Particularly in the current highly technological environment of perinatal care, continuous labour support (i.e. 80-90% presence) is valued because it is associated with a reduction of interventions, analgesia, and an increase in spontaneous vaginal births.⁸ Canadian women, for example, experience a variety of interventions associated with birth; 22% have induction of labour, 91% are electronically monitored for fetal heart activity, 60% receive epidural analgesia, and 26% give birth via cesarean section,⁹ while rates for cesarean section are generally similar or higher in other countries.¹⁰ Despite potential negative effects of technology, high rates of technology use continue because many providers work within a risk-averse culture that supports use of technology as supposedly protective of birth complications.¹¹

In North America, nurses' ability to provide labour support has recently been questioned because some studies have suggested the labour support nurses provide is too limited and does not reduce analgesia use or cesarean births.¹² This has been attributed to lack of training and role modeling, inadequate staffing, and a culture favouring technological expertise over labour support skills.¹³ Specifically, some authors have argued the introduction of labour technologies, such as electronic fetal monitoring (EFM) and epidural analgesia, have heightened nurses' technological skills to the detriment of labour support skills.¹⁴

Allegedly, nurses are progressively losing the art of labour support and replacing "high-touch care,"¹⁵ with "high tech."¹⁶ Implicit in arguments about a transition away from high-touch care is the assumption nurses historically provided more 'high-touch' labour support with more hands-on assessment and skill. Furthermore, this argument assumes high-touch care in the past facilitated more personalized and positive nurse-patient relationships.¹⁷ We wondered whether these assumptions about an alleged better labour support practice in the past might be based on supposition; hence, we have looked into the history of nurses' labour support provision.

Although it is not entirely clear when this alleged move away from high-touch care occurred, it is clear that technological advances, such as EFM and epidural analgesia, became commonly used in perinatal practice between 1970 and 1990.¹⁸ Thus, those two decades provide an important venue for exploring how these technologies influenced high-touch care. By means of an historical examination of perinatal care practices from 1970 until 1990, we explored the literature on labour support in the 1970s and 1980s and conducted oral history interviews with nurses who practiced during this time.

In this paper, we examine the context of labour support and birth during the 1970s and 1980s and also give a brief history of North American hospital birth as a background to this domain of nursing practice. By contrasting sociocultural contexts of the 1970s-1990 with current practice, we argue assumptions nurses historically provided more labour support with greater skill are misguided. We also argue current ideas about what would constitute best labour support practice can be nuanced based on a better understanding of how labour support

provision has evolved as sociocultural contexts change. We conclude with a discussion of the way our historical analysis might inform current practice.

Methods

There is no comprehensive historiography of hands-on assessment skills and labour support in perinatal care. Consistent with historical methods, we used document analysis to understand how labour support and hands-on care was constructed between 1970 and 1990 and how technology was perceived to influence nursing practice during that time.¹⁹ The Cumulative Index to Nursing Literature and Allied Health (CINHAL) sciences was searched, online (1982-present) and by hand (1970-1981). Specific journals, such as the Journal of Obstetric, Gynecologic and Neonatal Nursing (JOGNN), Maternal-Child Nursing, The American Journal of Nursing, and Birth were searched by hand. Reader's guide retrospective (1970-1982) was searched as well to find popular literature and nursing texts from this period were reviewed. No popular literature database between 1983 and 1990 was available.

To augment textual analysis, oral histories were conducted. Oral histories allow exploration of the sociocultural understandings about high-touch practice from those who experienced it.²⁰ They have been deemed a particularly effective means to uncover "missing evidence" in historical research,²¹ such as staff nurse perspectives, whose opinions are typically underrepresented in the published literature.²² Three registered nurses, Diane, Monica, and Pat, well able and willing to articulate their views, were interviewed after ethical approval was obtained from the University of British Columbia Research Board by the first author. All three nurses signed consent to participate and agreed to use their names in text. Oral history transcripts are with

the first author. All three worked as staff nurses during the 1970-1990 in labour and delivery care at two tertiary Canadian hospitals; two nurses (Monica and Pat) originally trained in Britain as midwives and received nursing registration after moving to Canada. Monica and Pat were interviewed together; while both were encouraged to contribute equally, Pat often deferred to Monica and agreed with her, as evidenced by fewer quotes from Pat.

While the number of oral histories were small and drawn from nurses' experience in the particular local context of maternity care in hospitals in British Columbia, these women's memories seem to reveal a different context of labour support, suggesting that current assumptions about past labour support practices might need to be revisited. In sharing memories nurses convey what they believe happened, shaped by later life experiences and the broader historical context.²³ Analysis of their stories provides insight into larger processes of social change and as such may provide one avenue to contextualize and critique current assumptions.²⁴ Their views importantly added to the findings from the literature.

A brief history of birth in North America from 1950-1990

By 1950, 95% of all births in Canada and America were conducted in the hospital.²⁵ Birth practices during the 1950s were highly regimented to decrease the chance of maternal infection and manage the sheer number of births during the post-war baby boom.²⁶ To facilitate compliance with obstetric practices aimed at efficiency and to meet women's alleged general desire for painless childbirth, most mothers were heavily sedated (and often unconscious) during labour and birth.²⁷

The declining birth rate in the 1970s meant parents increasingly viewed childbirth as a unique experience that needed to be satisfying.²⁸ Fueled by intersecting sociopolitical factors, such as women's health, consumer, and natural childbirth movements, parents challenged medical authority over women's bodies by lobbying for changes to birth practices.²⁹

For example, the natural childbirth movement became mainstream in the late 1960s to early 1970s³⁰ and was based on assumptions that childbirth generally did not need medical intervention and birth preparation could eliminate the need for pain medication and intervention.³¹ Women were no longer regarded as passive recipients of care, but as active consumers who could prepare for and engage in decisions about birth.³² By the 1970s, fathers were generally allowed in labour rooms and, by the 1980s, delivery rooms.³³ There was also a shift to rooms designed for women to labour, give birth, and sometimes recover in the postpartum period.³⁴

Technological advancements also changed perinatal care, particularly epidural analgesia and electronic fetal monitoring (EFM). Epidural analgesia became commonly used in the 1980s and was regarded as revolutionary because women were not sedated but could have virtually complete pain relief during labour.³⁵ EFM, introduced in the 1960s for high-risk pregnancies, became commonly used in the 1970s.³⁶ EFM allowed nurses to monitor fetal heart rates continuously and was intended to reduce the risk of fetal brain damage because nurses could see and respond to ominous fetal heart patterns.³⁷

EFM also left a permanent paper record that became relevant as North American culture became more litigious and lower neonatal mortality and fewer births meant families relied heavily on positive

birth outcomes.³⁸ Continuous EFM not only increased care providers' awareness of abnormal heart rate patterns but also motivated them to intervene; it is considered one of several factors that contributed to the rise in the cesarean birth rate between 1970 and 1990, which increased dramatically from 5.3% to 23%.³⁹

In short, between 1970 and 1990, hospital births shifted away from an experience in which mothers were sedated and alone to one where they were encouraged to have their partner support them during labour and birth. Labour and birth practices became somewhat more flexible as labour and delivery rooms were combined and mothers were permitted to engage in a variety of practices to cope during labour.⁴⁰ Mothers increasingly expected healthy infants in addition to satisfying birth experiences.⁴¹

Changing understandings of labour support and its importance

Since the 1970s, meanings around the concept of labour support and its importance also seem to have evolved. The term labour support is currently understood as a multidimensional concept. Currently, four common components in definitions of labour support include: tangible, emotional, and informational support, and advocacy.⁴²

Tangible or physical support includes measures, such as massage, handholding, effleurage (light abdominal massage), and any assistance, such as providing fluids, to increase comfort and reduce pain.⁴³

Informational support includes providing patients and family with information about procedures, labour progress, and care options, while emotional support typically relates to verbal encouragement that helps reduce anxiety and enhance coping.⁴⁴ Advocacy focuses on supporting patients' desires for their labour experiences.⁴⁵

Furthermore, as a part of labour support provision, nurses are strongly encouraged to practice one-to-one care, (where a support person is with a labouring patient 80-90% of the time).⁴⁶ While it does not always occur due to staff constraints (i.e. nurses are assigned 2 or more patients), one-to-one care provision is considered the epitome of quality labour support provision because one-to-one care has explicitly been linked to the use of fewer interventions during labour and birth and improved maternal satisfaction.⁴⁷

In contrast to this current conceptualization, such a multidimensional conceptualization of 'labour support' was not present in the literature in the 1970s and 1980s. In 1973, the Nurses Association of America did not include the provision of labour support as one of obstetric nurses' responsibilities⁴⁸ and the term "labor support" was not added as a subject heading in the CINAHL until 1993. It was only by the late 1980s that the term labour support began to emerge in the literature carrying the same connotation as it does today,⁴⁹ providing some indication nurses may have had different views about labour support care in the 1970s and early 1980s.

From our review of literature between 1970-1990 it appears one-to-one nursing care or constant nursing attention may not have been the norm or necessarily expected and the oral histories confirmed this view. In the oral history interview with Diane,⁵⁰ she recounted giving birth to her children in 1969 and 1973; "I don't remember any of the staff" because her nurse "was not there." She described being left alone; stating nurses only came to "check my fetal heart once every ½ hour."⁵¹ That oral history depiction was consistent with literature from that time, which consistently made reference to nurses leaving patients alone.⁵² In 1966, Tryon observed 30 nurses at 30-minute

intervals and counted the types of activities nurses performed during labour and deliver.⁵³ Only 6% of activities performed were considered comfort or support measures. These findings suggest all nurses did not readily employ supportive care or had other priorities that precluded its provision.

Even the idea of one-to-one support may have been novel between 1970-1990. It was only during the early 1970s the first studies appeared suggesting labour support reduced women's pain perception.⁵⁴ Studies suggesting continuous labour support reduced obstetric interventions did not appear until the early to mid-1980s.⁵⁵ The idea of providing continuous, supportive care with an alert patient probably was new in the 1970s. Interviewee Diane remembered being surprised and thinking, "you're really trying to do this?" when her supervisor began encouraging nurses to stay in patient labour and delivery rooms in the late 1980s because the practice was so uncommon.⁵⁶ In the 1970s and 1980s nurses may have been less aware of continuous labour support's potential to reduce the need for obstetrical intervention, which easily could have translated into unwillingness to provide it among some whereas other nurses were attracted to the idea.

Barriers and views about the centrality of labour support provision

Interviewee Monica noted it was the "number one priority;" although, she did not suggest all nurses shared this view.⁵⁷ When asked how much hands-on support, such as massaging and counter pressure (a form of pressure applied to a patient's back to reduce pain during contractions),⁵⁸ nurses provided in the 1970s and 1980s, Pat laughed, stating "we didn't do that," which may have reflected that she placed less value on labour support.⁵⁹ Diane explained "well, probably half of us gave

some value to that, I don't think that everybody was committed to that at all...I don't think I'm being unkind to the staff, they'd just prefer[ed] people to have an epidural." ⁶⁰ Monica echoed this; "there's nurses who are really very good at what you do and there are the nurses who are sitting at the desk when they should be giving support to the patient." ⁶¹ Diane explained some nurses did not provide labour support because they did not believe it was effective. ⁶² This is supported by Shields' (1978) study, in which 80 postpartum women were interviewed about their care. ⁶³ Based on interview data, each woman's nurse was categorized by the predominant type of care they employed. Similarly to Monica and Diane's description of 'two kinds of nurses,' ⁶⁴ 25 nurses were found to have only provided physical care (i.e. taking blood pressure), whereas 27 provided both physical and supportive care. ⁶⁵ The lack of labour support given by some nurses suggests nurses placed varying degrees of importance on labour support provision.

Probably nurses' 'valuing' of labour support was also influenced by staffing and the number of patients they had to care for. Monica, who viewed labour support as "a number one priority" also noted, "it didn't happen very often" because of "workload." ⁶⁶ Continuous labour support would have often been impossible in situations where, as Monica and Pat described, one nurse and one aide were responsible for 5 or 6 actively labouring patients. ⁶⁷ Diane, noted at her hospital the ratio was one nurse for two patients in the 1980s. ⁶⁸ Often patients laboured by themselves; Monica explained nurses "didn't have the resources to do it, and you know, and spend that much time with them." ⁶⁹

Lack of staff and high patient ratios may have reflected the nursing shortages

during the 70s and 80s in the United States and Canada. ⁷⁰ Even if nurses were skilled labour support providers during the 1970s and 1980s, lack of time may have prevented them from giving it.

Exploring differences in conceptualizations of skilled labour support between 1970-1990 and present

Exploring the relationship between the natural childbirth movement and nursing illuminates our current conceptualization of skilled labour support provision may not match what was considered skilled between 1970 and 1990. Today, skilled labour support providers are viewed as creative and skilled at keeping women informed, supporting their decisions, and coping. ⁷¹ Nurses are portrayed as facilitators who teach and support families to provide effective labour support; ⁷² nursing texts teach nurses how to support relaxation, breathing, and provide physical and emotional support to the labouring mother and her family members. ⁷³

These current labour support skills seem similar to natural childbirth methods described in the 1970s. During the 1970s, women increasingly attended childbirth preparation classes to educate themselves so they might have a natural birth with limited intervention and pain medication. ⁷⁴ As with current nursing texts, natural childbirth classes taught partners how to provide physical and emotional support and support their partner to relax and use breathing patterns. ⁷⁵ In part, the purpose of natural childbirth methods and labour support provision are similar, to support labouring women, as are the effects, reduced exposure to analgesia and intervention.

Yet, nurses seemed unfamiliar with these approaches in the 1970s. One article describing efforts to accommodate natural childbirth prepared mothers explained nurses were "skeptical and

resistant” to natural childbirth techniques.

⁷⁶ When discussing “natural childbirth methods” in a (1976) nursing text, McCaffrey ⁷⁷ explains:

Some of the techniques and pain relief methods of prepared childbirth initially appear, in all fairness and at the very least, simply odd. Not uncommonly the mothers feel foolish doing them and the nurses are shocked to see them. Hopefully the following examples will...encourage the nurse to investigate the situation rather than suspect that a laboring mother is mentally unbalanced.

McCaffrey does not list methods considered odd, but implies labour support techniques commonly used today, such as, breathing, positioning, relaxation, and visualization methods (i.e. breathing in through the mouth/out through the nose, changing positions, using massage, visualizing relaxing imagery during contractions), were the ‘odd’ methods, as she continues in text suggesting nurses should try to respect mother’s choices around those methods. Some labour support skills considered important and accepted today may have been unfamiliar and uncomfortable for nurses, at least in the 1970s.

The 1970s and 1980s’ literature and the oral histories suggested nurses did not commonly apply current labour support techniques at that time. Current nursing texts suggest using many techniques and tools, including: therapeutic touch, massage, aromatherapy, visualization, sterile water injections, birthing balls, and baths/showers, to reduce labour pain. ⁷⁸

Therapeutic touch involves touching the body to reduce the sensation of pain, while visualization includes envisioning a relaxing place or looking at photos during contractions to help relaxation. ⁷⁹ Birthing balls are exercise balls used for positioning during labour, while showers,

baths, and sterile water injections (injections of water into the lower back) are believed to interfere with pain processing and reduce labour pain sensation. ⁸⁰ In the 1970s and 1980s; however, physical comfort techniques described in texts and journals were limited to backrubs, effleurage, bed baths, and oral hygiene, ⁸¹ suggesting nurses may have held different perceptions around the scope of labour support practice in the 1970 and 1980s, as compared to current practice.

While the literature depicts a global unfamiliarity with natural childbirth methods, it is possible nurses were only unfamiliar with newer techniques, such as visualization, aromatherapy, therapeutic touch, and patterned breathing. The ‘hallmark’ of the Lamaze method (that was associated with natural childbirth) was patterned breathing, a newer method to cope with labour pain, where the mother used different breathing strategies according to her stage in labour to cope. ⁸² Diane, an advocate of nursing labour support and childbirth educator, suggested in her interview nurses at her hospital were averse when she taught them to use birthing balls in the labour 1980s. ⁸³ Moreover, she described having to attend workshops outside of the hospital setting in the 1980s to learn about labour support modalities, such as aromatherapy and therapeutic touch, suggesting nurses in-hospital did not know about them. ⁸⁴

Unlike today, nurses in the 70s were not construed as an important labour support provider; Lamaze and Bradley methods emphasized the father as labour coach. ⁸⁵ In a study examining fathers and nurses’ support during labour, it was found fathers were seven times more likely to touch the patient, and significantly more likely to provide a comfort item, such as a cool cloth. ⁸⁶ They were also present 97%

of the time, whereas nurses were only present 32%. Patients rated nurses' physical support actions during labour as significantly less helpful than the fathers. In other words, the influence of the natural childbirth movement may have been substantial towards increasing partner labour support, but less so at affecting the amount of labour support nurses provided.

Perhaps nurses' staffing levels presented barriers to staying with patients continuously, contributing to patient perceptions that nurses' support was less helpful than fathers' support. Alternatively, nurses may not have been taught skills to provide the techniques now considered necessary for effective labour support or had access to labour support tools, such as birthing balls and showers/baths now more commonly used.⁸⁷ Monica and Pat described in-room showers and baths were not available in the 1970s and Diane described birthing balls were not brought to her nursing unit until the late 1980s.⁸⁸ Monica and Pat made no reference to using a range of labour support skills, when asked about the care they provided; they primarily described assessments they performed.⁸⁹ When asked about how pain was managed, Pat only described epidural use and Demerol.⁹⁰ For Monica, providing support seemed to be equated with providing time rather than labour support care per se, making repeated reference to being with patients.⁹¹ For example, she explained she would "spend as much time as [she] could with the patients" and she "did the best she could."⁹² If nurses lacked skills or opportunities in the past to give care that might now be considered constituent of effective labour support, it undermines the current argument the 'art' of labour support is being lost.

Some nurses may have felt labouring mothers did not need elaborate breathing rituals and techniques to cope perceiving effective labour support was simpler between 1970 and 1990. When asked to define comfort, Monica described this meant spending time with women and letting them talk about their concerns because sometimes all they wanted was you to "say something little to them, say how are you doing, rub their back."⁹³ Nurses' views about what constituted effective supportive care between the 1970s and 1990 may have not fit our current conceptualization making it problematic to compare labour support skill in the past to current practice.

Changing understandings about the influence of technology on hands-on skill, labour support, and nurse-patient relationships

While we have highlighted problems around assuming past and current labour support practice are comparable, it is also important to highlight that current arguments about technologies' influence on labour support and hands-on care are narrowly constructed. Several nurse historians and researchers recently have argued the preponderance of labour technology, such as EFM and epidural analgesia, have contributed to a reduction in nurses' hands-on assessment skills, along with a reduction in the quality of nurse-patient relationships and labour support.⁹⁴ According to these authors EFM has contributed to a loss of hands-on assessment skill, such as fetal heart auscultation and contraction palpation, because EFM can monitor the fetal heart rate and contraction patterns for the nurse.⁹⁵ Some noted the availability of epidural analgesia technology in the 1970s has led nurses to rely on analgesia rather than labour support skills to manage labour pain.⁹⁶ Furthermore, allegedly EFM and epidural analgesia

seem to have inadvertently reduced the quality of nurse-patient relationships because they divert attention away from the patients and reduce the need for nurses to touch them.⁹⁷

Despite this same discourse taken up in the current perinatal literature, the view that technology has reduced hands-on and labour support skills and the quality of nursing relationships must be nuanced. While there is credence to the assertion nurses today may collectively have reduced hands-on assessment skills,⁹⁸ which Diane and Monica's oral history interviews also supported,⁹⁹ the introduction of EFM can be argued to have contributed to an increased presence of nurses at the bedside. Moreover, hospital rates of analgesia have persistently been high over time (in the 1950s women were also sedated), independent of epidural analgesia technology, suggesting nursing hands-on care and labour support, has never been sufficient in the avoidance of pain medications.¹⁰⁰

EFM use may have contributed to reducing the number of patients nurses had to care for, thereby allowing more time for nurses to cultivate nurse-patient relationships and provide labour support. EFM interpretation became standardized in the 1980s and nurses were the primary provider responsible for interpretation.¹⁰¹ In 1983, the American Academy of Pediatricians developed the first safe staffing standards dictating nurses should only be responsible for one or two continuously monitored patients;¹⁰² a sharp contrast to the 5 or 6 labouring patient ratios to which Monica and Pat referred in the 1970s.¹⁰³ As EFM use increased throughout the 1980s, this recommendation increasingly influenced staffing.¹⁰⁴ Monica acknowledged such a shift in nursing care: "now it's all one to one, so it's changed...in those days you

had no time."¹⁰⁵ Although, some authors argued the maintenance and interpretation of EFM took away from nurses' attention to labour support,¹⁰⁶ the time nurses' lost tending to EFM technology may be relative because nurses arguably gained time caring for fewer patients. It seems the nature of labour support changed along with the transformation of labour support technology.

Another form of technology that has been targeted for the loss of nurses' labour support skills is epidural analgesia. The challenge with implicating analgesia is that analgesia use has always been high in hospitals,¹⁰⁷ even during the peak of the natural childbirth movement.¹⁰⁸ One hospital reported Demerol was used 80% of the time to manage labour pain and some hospitals reported epidural rates of 75% by 1975.¹⁰⁹ In the oral history interviews, Pat described nearly all of her patients having an epidural, unless it was a "quick accelerated labour."¹¹⁰ Even nurses supporting natural childbirth patients were not taught to avoid giving pain medications, rather they were to try to give smaller doses and less overall.¹¹¹ The persistently high rate of analgesia use suggests, independent of labour support skill, some nurses have always used pain medication during labour.

If the supposition that nurses were more effective labour support providers in the 70s and 80s were valid one might expect a lower rate of birth intervention during that time because effective labour support is associated with reduced intervention rates. Yet hospital birth has never been low-intervention. Despite the skill in hands-on assessment skills before EFM, many interventions, such as episiotomies, oxytocin use, and forcep births were common. In Canada, 35% of women experienced forceps deliveries in the 1970s.¹¹² Leading in to the 1990s,

75% of women received an episiotomy,¹¹³ whereas today that figure is closer to 21% and forcep births, 4%.¹¹⁴

While the cesarean section and epidural analgesia rates have increased, it is unlikely a decrease in nurses' hands-on and labour support skills could be the sole reason. Birth has increasingly been constructed as a risky process leading to cultural perceptions that increased medical surveillance and interventions can ensure a safe birth.¹¹⁵ While there is dissent from normal childbirth proponents, research suggests patients are generally favourable to epidural analgesia and have become more favourable to cesarean section in the last 30 years.¹¹⁶ Epidural analgesia has increased in popularity, not necessarily because nurses did not provide effective labour support, but in part because it became more accessible and safe.¹¹⁷ Increasing epidural rates, more positive patient attitudes toward technology and cesarean section, fear of litigation, decreasing vaginal breech deliveries, and increasing maternal age and morbidity may have all have contributed to the current rate of cesarean section.¹¹⁸ Nurses' skill in labour support and hands-on assessment is relative in the context of changing sociocultural attitudes towards birth practices.

Discussion

This paper adds a historical perspective to the labour support debate, as previous historical work¹¹⁹ has only emphasized the influence of technology on hands-on assessment in perinatal care. Nurses may have possessed more hands-on assessment skills between 1970 and 1990, although it would be misleading to assume this meant they provided improved labour support, because the literature and oral histories do not suggest all nurses placed equal value on this care. Research supporting the value of labour

support was just emerging during this time. Its lack may have contributed to supportive care collectively holding less value than it does today. One-to-one care hardly existed due to higher staff-patient ratios, resulting in patients experiencing periods of their labour alone. Even if nurses possessed more skill in providing supportive care, it is possible lack of time to provide this care often prevented positive effects.

In the technological environment of perinatal care, it is presupposed that if nurses are skilled in hands-on assessment and labour support techniques they would be better able to support low-intervention birth. Furthermore, it is presumed that nurses were skilled in labour support and hands-on care in the past. Although our examination suggests nurses may collectively hold less skill in hands-on palpation and auscultation assessment techniques, the high rates of intervention even before the introduction of EFM suggest nurses' hands-on skills were not enough for births to remain low-intervention. Between 1970-1990 anesthesia rates were similar to current rates. Skill to support low-intervention birth may not be sufficient to overcome workplace environments where high technology and intervention are the norm or to resist sociocultural trends whereby many patients are favourable to pain relief.¹²⁰ As Diane succinctly explained "the reason we're not seeing changes [in birth technology rates] right now is women don't want it...those who do are not the majority."¹²¹

The difference in sociocultural context is important. Historians and sociologists caution against nostalgic thinking because it hinders reflection on current realities and taking action to address them.¹²² The latter authors suggest nostalgia has become increasingly pervasive in a postmodern society that laments

technologies' inability to fulfill its promise to improve humanity.¹²³ Likewise, the promises of epidural analgesia and electronic fetal monitoring to provide an easier, safer birth have not been actualized. Rather, these technologies have changed the context of perinatal care delivery and created new concerns. Nurses may have literally provided more hands-on care in the past but this did not mean analgesia or interventions were less common nor that care was necessarily better.

Historical work is valuable to help understand how current concerns have evolved. This study illuminates persistent themes in labour support provision. While we have emphasized nurses may have had high patient care ratios and lack of time to provide supportive care between 1970 and 1990, this issue resonates today. Despite a general awareness of the benefits of one-on-one care, often one-on-one staffing is still a luxury.¹²⁴ Similarly, current research suggests there are still 'two kinds of nurses;' those who highly value supportive care and those who do not.¹²⁵

Conclusion

While significant knowledge can be gained by exploring the past, imposing nostalgic ideas on current day practice may lead to unrealistic expectations of nurses. We have highlighted the different sociocultural environment of nursing practice in the 70s and 80s and argued contextual comparison between past and current practice is problematic because nurses may have appreciated and conceptualized labour support differently in the past. For nurse leaders to imply that reductions in interventions are entirely within the ambit of alleged supportive nursing is to ignore the current sociocultural context for birth that supports interventions. Expectations for high-touch care and labour support

should be redefined given the context of current practice. Nurses, care providers, patients, and nurse leaders need a collaborative approach to discuss barriers nurses face in providing supportive care and devise more comprehensive solutions than labour support certification.¹²⁶

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'She dined once at Major Bagot's with us, has an 18 inch waist, scarlet belt and makes up': The social exploits and behaviour of nurses during the Anglo-Boer War, 1899 – 1902

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Duty and respectability were two of the watchwords used when describing serving nurses during the Anglo-Boer War¹. At the commencement of war, nurses and women in general, were clamouring for the opportunity to experience the trappings of war and work alongside men as equal citizens in the defence and further expansion of the Empire. By this period British nurses were familiar with the endeavours of Florence Nightingale during the Crimean War, Anne Thacker's experiences as a volunteer nurse during the Franco-German War of 1870 – 1871; Florence Lees work 'In a Fever Hospital before Metz'; and Emma Pearson and Louisa McLaughlin's 'Adventures during the War of 1870 – 1871', all accounts which were available to purchase in printed form. In 1883, the Royal Red Cross award was established, with Sister Janet King a nurse and heroine of the Anglo-Zulu War of 1879, whose wartime work had featured prominently in the press, becoming one of its first recipients². This prestigious award provided nurses with tangible evidence of their service to the sick and wounded at the seat of war, a reward that would place them alongside Florence Nightingale, the nurse who had become 'the stuff of which myths are made' within her own lifetime³.

On the establishment of the Princess Christian's Army Nursing Service Reserve in 1897 the press had stated that, 'To the average nurse there has long been a rather romantic glamour about the work of her calling on behalf of the sea or land forces, and the possibility, if attached to the latter, that she might see (from the base) something of the actualities of war.'⁴ Whether it was primarily a call of d

duty to serve as a patriotic member of the wider Empire, or from a desire to experience the 'romantic glamour' of wartime service, hundreds of female nurses were enlisted into the Reserve during the three-year period of the Anglo-Boer War. It is perhaps unsurprising that many nurses, and women in general, wished to 'do their bit' with an increased jingoistic sense of patriotism sweeping the nation combined with a sense of duty, a prominent concept of the period which was identified as a woman's call to serve as a 'citizen' of the Empire.⁵ Female nurses would also have been attracted to wartime service by the increased opportunities to travel unchaperoned and to vicariously experience the theatre of war without the censure received by the 'lady war tourists' of the Crimean War era.⁶

Nevertheless, those nurses enlisting for wartime service with the sole intention of personal gratification and increased opportunities for travel and social exploits would have been condemned by many of their nursing peers and by the general public as 'frivolous'. To be labelled as frivolous during the late Victorian and early Edwardian period, an era heavily steeped in social ideals concerning the respectability and role of women would have been considered abhorrent by reputable ladies.⁷ The perceived image of the nurse during the nineteenth century was as either the 'good nurse', presented as a self-sacrificing angel, a woman ready to deny all in her dedication to those within her care. Or the polar opposite, the 'bad nurse': a woman who would willingly abuse her position of 'power and authority' for her own ends. These

prevalent images of the nurse as either 'good' or 'bad' are identified by Julia Hallam as the 'virgin/whore dichotomy'⁸ a discourse that continued through the First and Second World Wars, when nurses were frequently depicted as either a 'sexless white angel' or as a 'predatory and highly sexualised' woman preying on the officers or doctors in search of an advantageous marriage.⁹ Consequently it was imperative for nursing leaders to ensure that the public retained the image of the 'good nurse', with the drive for registration and professional regulation continuing apace in Britain. Princess Christian personally requested that senior nurses act as moral supervisors over other nurses while travelling to South Africa and to provide reports on those who did not behave appropriately to the head of the Red Cross and to Princess Christian herself.¹⁰ Strict control of the nurses while ensconced in the relative safety of the ship as to where they should sit at mealtimes and the hour of night that they should retire to bed was not possible on landing in South Africa where there were numerous opportunities for the nurses to 'frivol'.

Reserve nurse Emily Wood who was based at the Scottish Royal Red Cross Hospital in Kroonstad, was invited with her fellow nurses to attend a 'Cinderella Dance' and wrote in her diary that this invitation had necessitated her taking time out from her nursing duties to purchase a pair of white silk gloves, a pair of fancy slippers and some lace, so as to make herself a new cape, as the nurses had been forbidden to wear their official uniforms.¹¹ In Bloemfontein where an epidemic of typhoid fever was raging through the ranks, Dora Harris chronicled in her diary the many social events she had attended, despite the vast numbers of infectious cases to be nursed. Harris wrote:

In the afternoon Sisters Friend, Ross, Smyth and I went to Bloemfontein to buy material for fancy dresses for the Variety Race, and we sat up till 12 making them. The most absurd is the ballet girl's – pink tarlatan and roses. Mine is a Japanese Kimono, and the other two a clown and [a] baby.¹²

On another occasion Harris was assigned to night duty but managed to persuade another nurse, Sister Hopkins, to cover her shift until 3 am so that Harris could attend a local dance leaving at 2 am to return to complete her duty after 'plenty of dancing' and having enjoyed herself 'immensely' as it 'was very jolly, we all went in [our] uniform.'¹³ During their service in South Africa, nurses recorded in their personal correspondence their many varied excursions. They recorded their daily opportunities for horse riding or how they spent their off-duty hours in learning to ride. Nurses attended regular musical concerts within camps or in local towns, croquet and polo parties and went on numerous picnics across the veldt, alongside afternoons spent rowing with medical officers, before participating in games of cricket and hockey.¹⁴ Emily Wood proudly wrote to her family that she had formed part of the nurse's team who were pitted against the hospital's male cricket team, before going on an outing to the zoo to see the springboks.¹⁵ However, not all nurses were desirous of opportunities for 'frivolling' during their wartime service. Ethel Hope Becher, who by the period of the First World War was Matron-in-Chief of the Queen Alexandra's Imperial Military Nursing Service, had left her position at the London Hospital in December 1899 to enlist as a Reserve nurse.¹⁶ Becher, eager to distance herself from accusations of frivolling, wrote in a letter to Sydney Holland, the Chairman of the London Hospital House Committee, to

assure him of the London nurses respectable behaviour as representatives of the hospital in South Africa. Becher stated that, 'of course we have in many circumstances refused to go to picnics riding & driving parties in company with many khaki clad young men'. She further asserted unequivocally that she would be pleased to leave South Africa where:

We are associated in every way with a body of women so many of whom one feels ashamed to think were ever nurses, in fact I have been tempted to wish I had never come out to be mixed up in the mind of the public with such a collection.¹⁷

Eleanor Laurence recounted in a letter written in May 1901 at the General Hospital, Natal that:

There was a big dance the other night about three miles from here, to which twelve of the sisters went, and another night there were some theatricals. I daresay I am wrong, but somehow these festivities seem a little out of place while the war is going on. Some of the sisters appear to think that they have come out here to have as much fun as they can get, and talk about very little except the men they have been dancing with, and so on.¹⁸

Laurence remarked how, at first, the nurses had been encouraged to attend dances and riding picnics with men, until their conduct began to be talked of in an unfavourable manner.¹⁹ The nurses were subsequently provided with 'rules to conduct' which Laurence felt no lady should have been guilty of in any instance, although she was aware that one of her fellow nurses had been seen at a hotel at the next station 'smoking a cigarette with a most undesirable companion!'²⁰ The issue was one that she had cause to return to again stating that, 'though there are plenty of sisters out here who are working hard and well, they will probably all get classed together in the public estimation

with those who are simply "frivolling" [sic] and getting themselves talked about.'²¹

The preservation of respectability was also a consideration of Katharine Nisbet, matron of the voluntary Imperial Yeomanry Hospital in Pretoria, when rumours commenced that she had become engaged to a Mr. Thunder whom she claimed to have never actually had the honour of meeting. Nisbet wrote to her fiancé who was on a posting to Egypt that she had heard that the Mr. Thunder in question was already engaged (temporarily) to another nursing sister. The sister had boasted to Nisbet that this was her '5th since coming out' and had declared that she was already 'engaged to someone at home'.²² Nisbet was consequently anxious to ascertain what her fiancé's family thought of nurses as she claimed, 'If I heard the mere fact with no particulars that a brother of mine was engaged to a nurse, call her a Sister or a Matron or anything you like, I should be dreadfully worried till I knew what she was like.'²³ This Nisbet attributed to the fact that though some nurses were 'improved so immensely by uniform.... [and] by the regular rules of hospital life... People think them quite charming, so kind, so devoted and all that when not one in 100 is socially or any other "ally" quite all right.'²⁴ The worrisome behaviour of some nurses in South Africa was to be discussed further by Nisbet who continued:

Robin told us terrible tales of the hospitals at Bloemfontein. He says he has been ashamed to own to having a sister nursing out here. Round where he is they have a horror of the whole thing, hospitals + all connected with them + to be a nursing sister is tantamount to being no longer a respectable member of society. Isn't it terrible to think such things can be... They say it is the scandal of South Africa.²⁵

Nisbet was consequently aware of the ramifications to all nurses' perceived sense of propriety, with respectability contemporaneously understood as a style of living demonstrating 'a proper respect for morals and morality'.²⁶

Thus, the behaviour and perceived respectability of nurses was a key consideration during the reorganisation process of the Army Nursing Services. In 1901 Lieutenant-Colonel Alfred Keogh cautioned the War Office Committee, responsible for the reorganisation of the Army Nursing Services, that in his opinion he did not believe a group of women could be trusted with the power they were going to be afforded. Keogh qualified this as he believed a man to be much more 'honourable' than a woman. Women, he continued, were too likely to indulge in 'petty spites' and 'give it hot' to another nurse who usurps their position when going out into society within garrisons to enjoy 'tea, dances and dinner parties'. Women could not be trusted therefore to behave rationally in the face of social pleasures requiring guidance and support, as Keogh concluded, 'Women have not the same feeling about these things. Theoretically it may be all right, but practically, in a garrison town, where these nurses are very much in society, going out to dinner parties, and all the rest of it, if the Matron-in-Chief is not the head in the society they are in, and goes amongst them and takes the lead, that is what she will do.'²⁷

Women's historian Sheila Rowbotham states that as the twentieth century approached a new type of woman was required; although opinion differed as to how this 'new woman' should be defined and how much freedom she ought to be allowed, a concern evidently shared by the all male War Office Committee.²⁸ The 'new woman' debate featured prominently in popular fiction and the

press, questioning the changing role and situation of women and in some cases illustrating her 'dreadful behaviour; the fin de siècle literature and its shocking implications of free love'.²⁹ This 'new woman' was lamentable to a society where duty, character and chaste behaviour were paramount.³⁰ Victorian society did not view women as equal to men, women held no right to vote or even the opportunity to offer official input in to how their country, and to a larger extent, the Empire, was run.³¹ Women were seen as both physically and intellectually inferior and hence incapable of dealing with the realities of the male dominated public sphere where all major decisions were made.³² The issue therefore, was not merely how to win equal rights with men, but how to gain recognition for their achievements in a man's world in their own right, problematic when faced with the apparent opposition of men such as Alfred Keogh who believed women were not capable of holding positions of power and authority without indulging in 'petty spites' over alleged slights.³³ Women were thus to have a permanent place in the army hierarchy but their authority and power remained ambiguous and subordinate.

Once it was ascertained that female nurses would hold a permanent place in the sphere of war it was necessary to ensure that there would be no future scandals at 'the front' pertaining to nurses behaviour and decorum, or that female nurses would serve as a distraction to the medical men and officers.³⁴ The nurses who had travelled to the seat of war with a combined sense of patriotic duty and a desire for new experiences, which they would not encounter within civilian practice in Britain, had found themselves in South Africa with no head of nursing and a lack of defined control over a large body of women.³⁵ Following accusations

of 'frivolity' there was a need not only for reform, but also consideration of the future social experiences of nurses during periods of war and peace. An article entitled: Nurses, You Must Not Dance! by John Strange Winter in the early years of the new service's creation, relayed the recent discussions in Parliament regarding whether Army Nurses should be permitted to dance in their off-duty hours. The question was raised in the House, and Mr. Haldane, the then Secretary of State for War replied in a most extraordinary manner. Haldane stated that he had consulted the Nursing Board on the matter and had been advised that:

The Nursing Board requires for His Majesty's nursing service gentlewomen who are devoted first and foremost to their work for its own sake and for the sake of their patients, and who will, therefore, desire to live quietly and unostentatiously without looking for much gaiety.³⁶

The period between the Anglo-Boer War and the First World War appeared desirous of nurses who would behave respectably and not indulge in those 'frivolities' enjoyed by nurses such as Dora Harris, who danced till 2 am during a night shift or Emily Wood buying lace for new capes to attend a Ball in South Africa.³⁷

Yet the nurses who enjoyed the varied opportunities to 'go out into society' during their wartime service still demonstrated to many army medical officials the vital importance of good nursing to continued military efficiency.³⁸

This is suggestive that the nurses 'frivolity' was not entirely detrimental to perceived views of their professional status. However, it is apparent that by the period of the First World War, only twelve years later, that firm control over nurses' social exploits was in place with one nurse noting that, 'The rules regulating the

social life of the Sisters are very severe and social intercourse with the Medical Officers is prohibited.'³⁹ It is also possible to argue that once in South Africa, nurses had simply opted to enjoy the varied societal experiences available to them within the diverse environment of a garrison. Wartime service offered women the prospect of travelling abroad to experience 'every exotic detail' of war, which for many was viewed as 'a once-in-a-lifetime' opportunity.⁴⁰ Nurses also appeared eager to experience the trappings of war that had previously been the exclusive domain of men.⁴¹ Accusations of 'frivolous' were perhaps merely instances of women, constrained in civilian practice by strict social ideals of respectability and good moral conduct, partaking of those social activities readily available to them on a daily basis in South Africa during the last of the gentlemen's wars, within which the Victorian ideals of chivalry and a country-club atmosphere of polo parties and balls were still adhered.⁴² With advancing militarisation and recognition of the greater magnitude of future wars due to the advancements of modern weaponry and methods of warfare, an efficient and well-regulated nursing service was required. The next war would not be deemed a gentleman's war therefore the variances between the social experiences of nurses in the First World War to those during the Anglo-Boer War would have been starkly contrasting. The atrocities of the First World War would certainly have prohibited the 'country club atmosphere' and detracted from the 'romantic glamour' and 'frivolity' of previous campaigns. Warfare was advancing away from the gentlemen's wars of the nineteenth century and nurses were consequently required to advance too. This paper provides a brief insight into the social exploits and experiences of nurses during the Anglo-Boer War and

demonstrates the contemporary attitudes regarding the societal expectations of correct moral conduct and how accusations of 'frivolous' behaviour impacted on the views of both the medical authorities and nurses themselves. This is certainly an area for further consideration and examination regarding the debates surrounding the changing role of women alongside the move for registration in Britain with nursing reformers of the time stating that 'the Nurse Question' was also the 'Woman Question'.⁴³

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'An Unsuitable Job for a Woman?': Gender and Mental Health Nursing.

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Introduction

On the evening of Wednesday 12th May 1920 a demonstration took place in the city of Wakefield, in West Yorkshire. According to the 'Wakefield Express',¹ a large procession with banners flying, and with the city's band at its head, marched through the streets of Wakefield to the Green Market, where a large crowd had assembled. Two lorries acted as platforms for a series of speakers. Speakers on the platform included union officials, local councillors and representatives from the Discharged Sailors' and Soldiers' Association. Mr GW Newsome, secretary of the Wakefield branch of the

National Asylum Workers' Union (NAWU), proposed the following motion, 'That this mass meeting ... deplores the continued employment of female labour in male wards at the West Riding Mental Hospital – work which prior to the war was performed by men.'²

It was this topic that had aroused such passion. For the National Asylum Workers' Union, the headline in their magazine describing this 'great demonstration' expresses their views on the issue clearly, 'Female Nurses in Male Asylums Must Go!'³ Earlier attempts to discuss this matter with the asylum's visiting committee had failed,

the speakers said, and had led to this mass protest. According to Mr Newsome some members of the committee had grossly insulted them'. One member had told them 'to shut up and get out.' Another speaker, George Gibson (General Secretary of the NAWU), called for 'a clean sweep of the old fossils who run the asylum.'⁴

Clearly passions were running high. The objections to the employment of female nurses on the male wards appear to have two main themes. Firstly they claimed that ex-servicemen were unable to find work and speakers spoke of their 'dirty treatment.' Secondly it was not seen ⁵as women's work. Gibson spoke of the importance of a 'demarcation line between male and female employment ... it was absolutely unsuitable work for women to be employed looking after male patients.'⁶

The Great Divide

The origins of the mass protest in Wakefield are to be found in the design of the large Victorian asylums which were built across the United Kingdom. They all shared some common features, in accordance with the guidelines of the Commissioners in Lunacy. One of the most striking of these was the strict division of the asylum on gender lines, with a female side and a male side. Female attendants or nurses were appointed to work on the female side and male attendants on the male side. As Diana Gittins says, 'the spatial division of asylums by gender affected the daily lives and routines of all who lived and worked within them.'⁷

Strict rules kept male and female staff apart as well as patients. For example in 1914 the Manual of Duties for the County of Essex Asylums stated –

'Rule 223. The male and female patients shall be kept in separate wards and no male attendant, servant or patient ... shall be allowed to enter the female wards, nor any female to enter the male wards Any attendant or servant transgressing this rule,

unless a satisfactory explanation is given to the Medical Superintendent, shall be immediately suspended'.⁸

As David Russell argues, this great divide was prompted by Victorian fears about sexual misbehaviour by male staff towards female patients and fear of female patients becoming pregnant by male staff or patients, a significant issue in an era when mental illness was often seen as hereditary.⁹

What led to the breach of the 'great divide'?

At the protest meeting the employment of women was presented as a war time measure which had continued into peace time. It was undoubtedly true that mental hospitals and asylums had suffered severe staffing shortages during the First World War. James Gardner, in his study of the West Sussex Asylum, found that by January 1915 the asylum had lost 31 male nurses (or attendants) to military service, approximately one third of the male staff. Overcrowding, financial pressures and staff shortages led to conditions at the asylum reaching their 'nadir', he said, 'during the First World War.'¹⁰ This was replicated across Great Britain. Dr. Rambault, Medical Superintendent at St. Andrew's Hospital, Northampton (a private psychiatric hospital) reported at Christmas 1914 that he had lost 31 male attendants – thirteen had been called up as reservists and nineteen had volunteered. More left as the war proceeded.¹¹ Mental nursing was not a reserved occupation for men. The National Asylum Workers' Union's Journal contains many obituaries to its members who had been killed in action.¹²

However close examination of the history of mental health nursing reveals that the introduction of female staff onto the male side has its origins further back in history than the First World War. Fifty years earlier, in 1868, a writer in the Journal of Mental Science ¹³ asks the question, 'why should

female nursing be banished entirely, as it almost always is, from the male wards of our lunatic asylums?' He cites the famous psychiatrist, Dr. Maudsley, as a supporter of the introduction of female nurses to the male side and describes an experiment by Dr Crichton Browne at the West Riding Asylum (scene of the protests 50 years later) who introduced a female nurse onto the male side. According to Crichton Browne, 'good nursing is not to be obtained from blunt, unsympathising men, however well disposed they may be, it follows as an inevitable corollary that female nurses should be added to our sick wards wherever possible.'¹⁴ Despite the support of these two prominent psychiatrists this was not to become widespread practice in either England or Wales.

In Scotland however things were different and they, it could be argued, led the way in introducing female staff to the male side of the asylum. As Carpenter says, 'the motives were various.'¹⁵ One of the most vigorous proponents of this was Dr George Robertson, a leading Medical Superintendent, based in Edinburgh. In a series of debates he put forward 3 main arguments, Firstly, he said, male patients would co-operate more with female nurses. He claimed, 'the presence of women has always had a refining influence on male society ... excited patients who are ready to fight any man who comes near them, will often do anything they are told by a nurse, and they will become calm if they receive a word of sympathy from her.'¹⁶ He also argued that asylums should become more like hospitals and thus, 'the employment of female nurses in the male wards in Scotland was in fact, only a part of a much greater ideal – that of the hospitalisation of the asylum.'¹⁷ Lastly he said that nursing was women's work, 'If it could be alleged of any asylum that its male wards were not a suitable place for women, then the sooner a reformation was effected the better.'¹⁸

The NAWU however interpreted this differently. For them female labour represented cheap labour as female nurses were paid substantially less than men in this period. Therefore employing more female staff did allow the Scottish medical superintendents to improve their staffing ratios as more nurses were employed for the same amount of money.¹⁹

Why the protests?

Once this practice became more widespread during the First World War the NAWU's leadership pursued a vigorous campaign to stop it. In January 1916 the union put forward the following resolution to the Labour party's 15th annual conference –

*'That this conference records its emphatic condemnation of the system, now being increasingly adopted in Public Lunatic Asylums, of substituting female for male attendants in the care of insane male patients at reduced rates of wages, believing the practice to be morally indefensible, detrimental to the welfare of both patients and nurses, and economically injurious to the Asylum service as a whole and calls for its immediate abolition.'*²⁰

Each month a 'Roll of Dishonour' or 'Black List' was published in their magazine listing those asylums who were employing female labour on male wards.²¹ By 1920, two years after the end of the war, the practice continued. The union deplored 'the degrading system of female nursing of insane male patients in asylums' and argued that a temporary expedient in war time was being retained in the interests of economy. In very few asylums, they argued, 'were the women who undertook these revolting duties paid the male rate of wages for performing male duties.'²²

A small victory was won when the female nurses at the Durham County Asylum were withdrawn from the male side but other asylums remained obdurate.²³ The union

fought on for the next decade adding new arguments to support their cause –

* The union had female members who did not want to work on the male side and they were also representing them- ‘a good number of our female members who had experience of this class of work during the war will tell you that they detest it and are entirely opposed to it, although they are compelled to undertake it.’²⁴

* The union also argues they wished to protect women ‘from the moral and physical dangers attracting from such work’.²⁵ One speaker at the annual conference in 1931 said, ‘I have twenty-four years of experience of mental hospital work and I would rather follow my daughter to the cemetery than she should go into the male ward for duty.’

²⁶ In 1936 the union’s journal reported the case of a female charge nurse at the Crichton Royal, Dumfries, Scotland who had been imprisoned. She had given birth to a baby in her room in the nurses’ room and then smothered it. The father of her baby was a patient.²⁷ Male patients were also seen as dangerous and case studies were used to support this point.²⁸ The death of a female nurse in France at the hands of a male patient was cited.²⁹

* Male patients also needed protecting from female staff, it was posited. Another speaker at the union’s annual conference stated, ‘when proper control is absent one may assume that the presence of females will unduly excite the perverted sexual tendencies of these patients and lead to an increase of such habits, with consequent retardation of their recovery.’³⁰

* Male nurses were better trained than women. A letter of protest from the Tooting Bec union branch (London) to their local paper argued that 45% of the male staff had completed their training and only 8% of the female staff.³¹

* More pragmatically the union pointed out that there were chronic shortages of staff on

the female side so moving them to the male side was merely exacerbating this process.³²

* Lastly they claimed that recovery rates were lower for men in asylums with the highest ratio of women on the male side³³ and death rates were higher.²⁴

What did the female nurses themselves think?

As Mick Carpenter says, ‘the campaign undoubtedly showed the strength of male values in the union, although it had some support among women who did not want to work in the male wards’³⁴ As mentioned above, for some women working on the male side was not an attractive proposition and in 1931 a petition to the London County Council calling for the abolition of this practice in the mental hospitals they administered contained over 2,400 signatures, of which nearly half were female.³⁵

However for other nurses, it was something they supported. One female nurse in a Lancashire asylum using a pseudonym (‘Lancastrienne’) wrote in the union magazine in 1929, ‘it is an insult to a great number of patients to infer that all mental cases are depraved ... It is neither right or just to deprive them of the ‘human’ touch, and the uplifting influence and help that a good trained woman can give them ...I have always been treated by respect by the patients, and heard much less bad language than one hears in most workshops’³⁶

In 1920 a series of scandals at the Cardiff Mental Hospital in Wales led to nurses giving evidence to the Visiting Committee. Again female nurses were in favour of this nursing male patients, One, Sister T. Morgan, argued, ‘she would nurse male patients in preference to female as they were less spiteful.’³⁷ At the Edinburgh Royal Infirmary, nurses signed a document to be presented to the Medical Superintendent, George Robertson,

‘we, the undersigned, being nurses actually engaged in the nursing of the insane, desire

*to express our strong disapproval of the attitude taken by the Asylum Workers Union ... and respectfully urge upon you the necessity of opposing the Union's demands for the abolition of a system which has proved itself so well adapted to the needs of our patients.'*³⁸

This was however interpreted cynically by the union as being secured under duress, 'we imagine that woe betide any nurses who refuses to sign.'³⁹

And what of the patients' views?

It is difficult to tell as patients' voices are largely hidden in the history of mental health care. As one female nurse argued in the union's magazine, 'I only wish an impartial committee could ascertain the poor patients' point of view as regards the value of our work'⁴⁰

Conclusion

Despite the union's best efforts female nurses on the male side of mental hospitals remained as a feature of many twentieth century psychiatric institutions and their campaign ultimately failed. It was to be some time before male nurses were allowed to nurse women, or male and female patients were nursed together in mental health institutions.

Mental health nursing has followed a different historical path to general nursing and one of the most striking features of this has been the much greater numbers of men who have worked in this speciality (as also has learning disability nursing). By 1924 when the debate that has been discussed was at its height, only two general hospitals were approved to train men.⁴¹ This period also saw the name nurse being applied increasingly to male staff in asylums to replace their former title of attendant. Male nurses thus challenged gendered stereotypes of nursing as 'women's work'⁴² as can be seen in the debates that have been analysed. Mental health nurses were also more unionised and argues Miers, presented

a challenge because of their 'self perception as workers and employees, untroubled by ideas of vocation or profession.'⁴³ This issue was also thus very much about pay and conditions.

In his work, Mick Carpenter argues for the use of a 'social divisions' approach. Nursing must not be analysed in isolation he says, but in a broader context where issues such as this are 'crucially affected by balances of power in the wider society, which became represented in the health care system'.⁴⁴ Thus debates about women's work were much broader than this across the 1920s and 1930s.

While this campaign was ultimately unsuccessful though, these insights into a contentious topic give a fascinating insight into gender roles and stereotypes in mental health care in the early twentieth century.

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Brief Biographies:

Charlotte Seymour Yapp

Claire Chatterton and Lesley Wade

Charlotte Seymour Yapp was born in October 1879, in Ardwick, Manchester, to Moses Yapp, a railway guard, and his wife, Sophia (nee Seymour), a seamstress. She trained as a nurse at Aston Union Poor

Law Infirmary at Erdington, near Birmingham, completing her training in 1903. She then gained her certificate in midwifery, did private work and worked as an infant health inspector in Lancashire. An active member of the Poor Law Nursing Association, posts followed in Keighley, Halifax, York, West Hartlepool and Tynemouth before her appointment, in 1914, as Matron of the Lake Hospital,

Ashton-under-Lyne. She remained there for the rest of her career until she resigned, through ill health, in 1925. She died in 1934.¹



MISS G. SEYMOUR YAPP.

Miss Yapp is little known in nursing history yet she played, it could be argued, a significant role in the early days of the General Nursing Council (GNC) for England and Wales, and was a doughty defender of the interests of Poor Law nursing. Nursing and the health needs of Lancashire were relatively unknown to the voluntary hospital matrons of London, who, as a result of the formation of the GNC following the Nurses Registration Act of 1919, were crafting new rules, regulations and restrictions on nursing, and not always attending to one of the largest providers of care, the Poor Law nursing service.² Politically powerful, this elite London group has previously dominated nursing history.³ Miss Yapp was appointed to the first caretaker council of the GNC in 1920. Only four of the 16 nurse members represented Poor Law Hospitals. She was the only one who had also trained in one.⁴ In 1923 when the first GNC council was elected, she was elected unopposed and served on the council until ill health forced her resignation in 1925.⁵ The Poor Law

Officer's Journal⁶ paid tribute to her efforts saying "Miss Yapp was a member of this body in troublesome days. At that time it was no easy task to hold the claims of the poor law in surroundings distinctly hostile...Week after week, month after month, Miss Yapp put the poor law case ... in the end they were compelled to acquiesce ... the fight is over but the nursing side of the poor law in respect of state registration owes more to Miss Yapp than is realised, the whole poor law is in her debt." 'Not in the North' was the maxim Yapp used at GNC meetings to challenge lowering nursing wages, restrictions on working hours and the setting of unattainable entry requirements and it is clear from the minutes of these early meetings that Yapp had to fight constantly to ensure that her voice, and those she represented, was heard.⁷ Clearly she was, as one of her main antagonists, Mrs Ethel Bedford Fenwick, noted, always well informed and able to put her views forward "forcefully."⁸ She was also a prolific author, contributing regularly to the Poor Law Officers' Journal. She wrote a series of lecture notes to probationer nurses⁹ and edited the journal's nursing section between 1910 and 1925. She also contributed to the first syllabus for nurse training published by the GNC in 1925, based on the pioneering training scheme she introduced at The Lake Hospital in 1916.¹⁰ She published textbooks on medical and surgical nursing and children's nursing.¹¹ In a poignant letter written to a friend in 1926, after cardiac problems had led to her enforced early retirement at the age of only 46, she wrote "all that I have done will be forgotten."¹² She deserves to be remembered as a pioneering nurse and author and as a champion of the Poor Law nursing service and the needs of sick children.

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Obituary:

Lesley Wade (1955-2013) Nurse, historian and lecturer

Claire Chatterton, Chair of the RCN's History of Nursing Society

Nurse historian and lecturer at the University of Manchester, Lesley Wade (née Savage) has died aged 57.

She will be remembered for her compassion, professionalism and enthusiasm about the past, present and future of nursing.

Born in Lancashire, Lesley, met her husband, Eddy, while sailing, a hobby which gave her much pleasure and which she enjoyed sharing with her niece, Emily, and nephews, Huw and Rupert.

She trained as a nurse in London, at King's College Hospital, and then moved to work in the Intensive Care Unit at the Westminster, where her identical twin sister, Rosie was training. Understandably this was to lead to some confusion amongst the hospital staff and was a time that was remembered with great fondness by them both. She then moved back to the North West and was to work

in intensive care in this area before she opted for a change of speciality to working with older people. She held one of the first joint appointments between the School of Nursing at Tameside and the Nursing Development unit for older people. Her then manager, Dame Betty Kershaw said of Lesley, "She was a star, pioneering these new roles, teaching and practising at an excellent level. She was to host international nurses who came to see the unit ...and was to go overseas to teach elderly care. She was in Malta at the hospital there at the same time as Reagan and Gorbachev were having their vital discussions on concord and co-operation". She then moved to work as a lecturer at the University of Manchester and through her work there for nearly twenty years, was able to pass on her knowledge and skills to many students. Together with Lesley Waters she was to publish an important addition to the literature on nursing older people in *A Textbook of Gerontological Nursing: Perspectives on Practice*, in 1996.

Lesley took an active part in nursing history organisations, including the RCN's History of Nursing Society committee (of

which she was Chair and Newsletter Editor) and the University of Manchester's UK Centre for the History of Nursing and Midwifery. Amongst her research interests was the career of Charlotte

Seymour Yapp, an early twentieth century matron in Ashton-under-Lyne, who championed the cause of Poor Law nursing, then the poor relation of the powerful and higher status voluntary hospitals.

Festival of Learning showcases the History of Nursing

Angela L. Turner-Wilson, Sarah Keeley, Petra Brown, Gill Jordan, Cate Wood, University of Bournemouth.

The Festival of Learning was an event held at Bournemouth University between the 3rd and 14th June 2013, which provided a forum where staff could share their work with members of the general public. Academics in the history of health group (originally set up by the now sadly deceased Associate Professor Dr Francis Biley, and part of the Research Centre of Health, Wellbeing and Ageing) were keen to participate. An exhibition stand was set up for the Festival, and this showcased, amongst other things, the history of nursing (Figure 1). There were old photographs and nursing texts on display, and visitors could view training slides dating from the 1960s. Some of the staff wore their old uniforms, and visitors could even see some old cardboard hats (see Figure 2). There was a research poster on the history of clinical skills education by Keeley et al¹, and there was an opportunity to listen to recordings taken for an Oral History Project which drew on the memories of retired nurses. A number of people came to see the stand, and many of them shared their thoughts about nursing in the past. Some offered very different views into 20th century healthcare. The exhibition stand was a success both in terms of providing an interesting event for those visiting, but

also as a means of increasing knowledge about nursing history. It is anticipated that some of the insights will be fed back into nursing programmes at Bournemouth University and any future research projects.

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Figure 1. History of Health Exhibition Stand, Festival of Learning, Bournemouth University. (Photo: courtesy Angela L. Turner-Wilson)



Figure 2. Old cardboard hat, History of Health Exhibition Stand, Festival of Learning, Bournemouth University. (Photo: courtesy Petra Brown)

'Colonial and post –colonial nursing' - History Of Nursing Colloquium

Allison O'Donnell, University of Dundee

The UK Association for the History of Nursing Colloquium 2013 took place at the University of Oxford, Oxford on the 4th July 2013. This was a truly international event with a wide range of presentations exploring the Diaspora of nursing and nursing work overseas and an overall theme of where and how nurses work with people who were in a colonial setting or who were in areas of conflict and through missionary work. There were over 80 attendees from an international perspective, and within this also some Masters and PhD students, all with an interest in nursing history or womens' history. To open the day, Professor Anne Marie Rafferty delivered the keynote speech, on behalf of Rosemary Wall as well, and this inspirational presentation was entitled, 'Embodying Nursing' in the British Empire, 1896-1946'. This paper eloquently explored the recruitment and selection of nurses who were sent to work for the British Empire in various colony countries. With the use of advertisements from the time, primary interview notes describing the nurses' physical characteristics and personal traits, and photographs of the uniforms that nurses were required to wear at all times, Anne Marie brought to life, the work and roles that the nurses adopted during their postings overseas.

This work overseas, was then continued as a theme by Dr Susanne Malchau Dietz who considered in her paper, 'Gender, Vocation and Professional Competencies: Deaconesses in the Danish West Indies 1904-1919' the role that Danish nurses had during this time and also explored the royal patronage which Danish nursing has had.

After coffee, Dr Aya Homei presented her PhD work where she has investigated the remit and work of Japanese Public Health Nurses from 1950 until 1970, in supporting and instructing mothers and families in their family planning. Aya explained that after WWII, the Japanese government was subject to American influences in the way in which family planning was directed, with public health nurses being at the forefront of educating women as part of national birth control experiments.

In the last session before lunch, Dr Barbra Mann Wall gave a detailed and elucidatory presentation exploring her work related to the Medical Missions in Nigeria from 1937 until 1970. Barbra explained that this Mission's work has mirrored Nigerian society, having to change and adapt over this period of time. Barbra also noted that her archival sources have also changed, and she has recently found a RTV link, from which she now has access to small religious [Medical Mission] Sisters community in Dublin.

After lunch, Dr Sam Goodman took us on a literary journey as his presentation, 'Lady Amateurs and Gentleman Professionals: Ad-hoc Nursing in the Indian Mutiny', which drew on the primary diaries of the wives of Army serving officers and other ranks who were stationed at Lucknow during the Indian Mutiny of 1857. To illustrate his work, Sam utilised known paintings of the day depicting this event, the womens' dairies which were from differing social classes and from all of these sources Sam described the nursing role that the women took in caring for the men who were injured or died during this mutiny.

The Irish theme from Barbra's paper the morning, was continued with Dr Gerard Fealy's paper, 'Genial and Accomplished ladies': Irish Nursing and the Colonising Project' and explored the role that the

Irish women carried out when sent to different colonies.

The theme of going overseas, was carried on into the colloquium and 'made real', as with the use of a Skype link, the audience was transported to Australia to see Dr Odette Best present her paper on the 'Training 'The Natives' as Nurses: So What Went Wrong? An Australian Context'. This presentation covered, vividly, the systematic government lead way in which the Aboriginal peoples of Australia were treated in terms of their health care. At this time, their culture heritage, health beliefs and land rights were not adhered or accepted by the government of the day. Against this societal thinking, Odette explained how Aboriginal nurses were trained as they attempted to establish a professional role for themselves.

After tea break, Dr Susan Armstrong-Reid explored the role of Elizabeth Hughes who worked as a Guerrilla Nurse with The Friends' Ambulance Unit in remote parts

of China – again the use of photographs as a record illustrated this well.

The last paper of the day was from Anna La Torre, Giancarlo Celeri Bellotti and Cecilia Sironi and explored the role of Italian nurses who were working in the war zone at front lines of the Imperial War which took place from 1935 to 1936 in Ethiopia. This paper drew on the nursing and medical records from this time of Fascism, and considered how nurses worked at time of conflict in a Fascist state.

This colloquium was a very interesting and thought provoking day. Notably, it was also convenor and organiser, Dr Helen Sweet's last colloquium as Helen retires from her working life, but not from her interest in history and nursing history. To mark this new chapter in Helen's life, Dr Claire Chatterton, Chair of the RCN History of Nursing Society and Professor Christine Hallett from UKAHN, both presented flowers to Helen to wish her well in her retirement.

An Accidental historian

Janet Hargreaves, University of Huddersfield

I started my State registration nurse training in 1975, three quarters of the way through a century which had seen significant change in nurse education in Britain. The apprentice- based system that emerged out of the Nightingale era was validated as the route to registration when the General Nursing Council was formed in 1919¹. The training model was continually challenged by policy directives culminating in the Athlone Report of 1939 that sought to make nurse training shorter, more efficient and fit for serving the hospital sector. The Royal College of

Nursing's own commission, the Wood Report of 1943 echoed some of the recommendations of Athlone, but particularly wanted to promote nursing as significant career aspiration for women. The changes espoused by both were resisted from within the profession and by the powerful hospital administrations². Slowly however, curricula did change and experimental degree level courses started to emerge from the 1960s onwards. Full transition from nursing schools affiliated to hospitals, where student nurses were contracted as trainee employees to full supernumerary status, a bursary and a university education was negotiated by the 1990s and finally sealed with degree status for all in 2012.

As a student nurse I was utterly oblivious to these changes. In the county town of Shrewsbury in Shropshire, I joined a traditional nursing apprenticeship. A 6 week 'pre training school' inculcated into us the values expected, taught us how to wear our uniforms and offered a crash course in nursing procedures, anatomy and physiology. Three years of placements typically lasting 12 weeks and including two or four weeks on night duty, interspersed with 4 week 'blocks' of study introduced me to the range of nursing practice. The military precision of the nursing rotations was matched by the regular move from room to room in various nursing homes, so that we were never more than ten minutes from the hospital door.

There were of course signs of the times had I known to look for them. We were solemnly informed that we were to have our own key to the nursing home front door, and that we were to use this responsibly. Our 'set' of around 25 students included two men and a number of commonwealth students. At 19 I was one of the older students, but a few were several years my senior and one married student 'lived out'.

In practice most wards had a traditional task oriented policy; the ward sister kept a work book for the day listing the activities that each person was allocated to complete. Starting on an early shift at 7.15, we checked the book for our allocation which might be one side of the ward, one bay, 'baths' or 'investigations' which meant doing all the specimen collections. However the children's ward was an experimental unit, using and evaluating the newly envisioned 'nursing process' that was to become the backbone of nursing curricula for decades.³

Many years later, now working in higher education as a nurse lecturer, I embarked

upon my Dr. of Education and was searching for a topic for my thesis. Conscious of trying to offer a meaningful curriculum in a setting now dislocated from practice, I wanted to explore the extent to which, if at all, the development of reflective and critical thinking helped students learn to nurse or made a difference to the care they gave. I was wrestling with the methodological challenges this offered when a chance encounter led me in an unexpected direction.

My mother had always said that she had a cousin who had been 'something in nursing'. She reminisced about meeting her in her nurses' uniform in their home district of Walthamstow, London, early in World War Two. I can now date this to the period in 1940 when cousin Alice was completing the district practice section of her midwifery training and was stationed in the Walthamstow area. Alice remained in London, navigating the blacked out streets on her bicycle, and sleeping in the hospital basement along with mothers and their newborn babies when air raids made the wards too dangerous. My mother was evacuated to Shropshire and they did not meet again until we traced Alice 55 years later. A frail but spry lady in her 80s Alice was a revelation: sharp, intelligent, with an encyclopaedic memory and a genuine joy in talking about nurses now and in her own past. Alice became for me the 'serendipitous' happening that Plummer⁴ says can lead to the collection of life histories.

We started to meet regularly and over a period of a few months we constructed her life history from commencing tuberculosis nursing in the 1930s to retirement from a senior educational post in the 1970s. Although the whole of her career was full of interest, the particular focus for me became the 10 years (1945-1955) that she has spent running the 12

week pre- training school for a well respected nursing school; a precursor to the one I had myself attended, and which had now disappeared from nurse education.

She opened doors that allowed me to interview nine further retired nurses, and I asked them to remember the aspects of pre training school during this same 10 years that contributed to their understanding of what it was to be, or to become, a good nurse. I had been reading Julia Hallam's work on nursing image⁵ and so, mindful of the professional and public images of nursing as well as the autobiographical, I also undertook archival work, visiting the RCN archives in Edinburgh to analyse the *Nursing Times* and *Nursing Mirror* which were popular nursing journals of the same period.

Through this research I felt that I began to hear the 'voice' that they and the literature from the period used to describe nursing and nurses. I began to understand better the transition from individual to nurse, and the ways in which the training capitalised on class and gender to mould the recruits into the 'right kind' of nurses. Then as now, the organisational culture in places where nurses practice plus the discourses around caring, professionalism, vocation and gender exert a powerful influence on the ways in which what nurses learn in their training translates into the way they nurse. I felt that by accidentally stumbling into a historical study, I had achieved what I set out to do; to understand better the ways in which good nursing could be supported through education.

The richness of data available to me was a revelation and I was hooked on history. I used some of the varied sources of evidence available to me, critiqued in detail by Chatterton⁶. Firstly life history research permitted an in-depth exploration of an extended period of

history from the view point of someone who lived thought it⁷. As women in general and nurses in particular are not well represented in main stream historical research and publications⁸ this helped me to find a critical edge that had eluded me until then.

Secondly a major source of data is the lived memory of nurses. We have a longstanding narrative culture, and so I found nurses very willing to share the stories of their nursing lives. The data that can be gained by interviewing nurses is a huge, rich resource. Any method that relies on the memory of participants is subject to limitations, and historical interviews are no different to this. However many of the nurses I interviewed volunteered documents and artefacts that they had kept, which helped them to locate and challenge their recall. These included for example the three year record they were required to keep, where each task learned - a bed bath, an injection - was signed for by the ward sister, a record book that included all of the nurses shifts, holidays and sickness for three years and a beautiful hand sewn arm splint which she had made during PTS. It was also possible to triangulate their memories with reference to other sources which lead me to the third area which was archives. The archival documentation available to nurse researchers is extensive and varied. From the digitalised Public Records Office to small collections relating to individual hospitals, a wealth of material can be sourced and analysed.

I started out curious to explore the relationship between what nurses are taught and the sort of nurses they become. I now understand more about this by studying the past, than I think I could have gleaned from researching my contemporaries. Writing now, in 2013, all UK nursing students will gain honours

graduate status as well as their nurse registration. Behind them stand the shadows of my own nursing training, of Alice and her nurses 60 years ago, and beyond them the architects of modern nursing in hospitals, asylums and communities in the 19th century

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Hotel Dieu in Beaune

Carolyn Gibbon, Independent scholar, previously University of Central Lancashire

During the summer sojourn to the south of France this year, we had the opportunity to visit the Hotel Dieu in Beaune. This is a remarkable building which was built as a hospital in 1443 by Nicholas Rolin, chief justice to the Duke of Burgundy. The hospital was built following a period of famine and epidemics following the Hundred Years War, and dedicated to St Anthony the Abbot. There is evidence of a matron being appointed

to oversee the care of the patients in the 30 bedded Paupers' Ward. The nurses of Beaune were held in high esteem as in 1632 the local magistrates in Chalon-sur- Saone decided to replace their civil nurses with hospitaller sisters from Beaune. In 1645 further wards are added as the need for care grows. The hospital continued to provide care until 1955, though some care for older people continued until 1984. During the 19th and 20th century the hospital has undergone various restoration projects and in 1988 the hospice opened as a museum. Highly recommended, if you are in the area.



DATES FOR YOUR DIARY

UKCHNM SEMINAR SERIES 2013-2014

(Generously supported by the Manchester Royal Infirmary Fellowship)

Wednesday 25th September 2013: Carolyn Gibbon, University of Central Lancashire, 'Voices from the Royal Infirmarys'. **Room G306A** in the Jean McFarlane Building

Wednesday 16th October 2013: Dr Stuart Wildman, University of Birmingham, 'Nursing the sick-poor at home: the work of the Manchester Nurse Training Institution and its successors 1864-1958'. **Room 2.5** in Roscoe Building

Wednesday 13th November 2013: Dr Tommy Dickinson, University of Manchester, "'Curing Queers": Mental Nurses and their Patients, 1935-1974'. **Room G306A** in the Jean McFarlane Building

Wednesday 19th February 2014: Dr Deborah Palmer, 'Caring for the nurses? The occupational health of nurses in the late nineteenth and early twentieth centuries'. **Room 2.324** in the Jean McFarlane Building

Friday 14th March 2014: Dr Sue Hawkins, University of Kingston-upon-Thames, 'In the end, it all comes down to money: nursing in Manchester in the 1860s'. **Room G306A** in the Jean McFarlane Building

Wednesday 14th May 2014: Dr Rosie Wall, University of Hull, "'Training Nurses for the Tropics": London, Liverpool, Manchester and Edinburgh'. **Room G306A** in the Jean McFarlane Building

UKAHN COLLOQUIUM 2014

!!ADVANCED NOTICE!!

The 2014 Colloquium will be held in July at Kingston University, Kingston-upon-Thames.

The first day will be the PhD workshop with the Colloquium being held on the second day.

Watch the website for further details and book early, as places will be limited.
